DESIGNING A TWENTY-FIRST CENTURY MEDICARE PRESCRIPTION DRUG BENEFIT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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DESIGNING A TWENTY-FIRST CENTURY MEDICARE PRESCRIPTION DRUG BENEFIT

TUESDAY, APRIL 8, 2003

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123 Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Barton, Upton, Deal, Burr, Whitfield, Norwood, Wilson, Shadegg, Buyer, Ferguson, Rogers, Brown, Waxman, Pallone, Green, Strickland, Capps, DeGette, and Dingell (ex officio).

Also present: Representative Allen.

Staff present: Chuck Clapton, majority counsel; Steve Tilton, majority health policy coordinator; Patrick Morrisey, majority deputy staff director; Eugenia Edwards, legislative clerk; Bridgett Taylor, minority professional staff; Amy Hall, minority professional staff; Karen Folk, minority professional staff; and Nicole Kenner, staff assistant.

Mr. BILIRAKIS. The hearing will come to order.

As per new rules of the House, any members who are here at the time of the gathering will have the opportunity and, hopefully, to waive their opening statements so we can get right into the witnesses, have that additional 3 minutes at the time of inquiry. Mr. Brown and I will have 5 minutes under the rules for an opening statement.

I call to order this hearing of the Health Subcommittee. I'd like to, on behalf of myself and other members of the subcommittee, thank our witnesses for taking the time to appear before us today, and I am sure, and certainly hopeful, your testimony will prove valuable, as we consider the challenges inherent in designing an affordable Medicare prescription drug benefit.

The Energy and Commerce Committee, and, particularly, this Health Subcommittee, has held numerous hearings on the need for a Medicare prescription drug benefit over the last few Congresses. I'm sure that with each of these hearings we all have taken away a particular point of view, but the one thing I'm sure we can agree on is that while prescription drugs have improved the lives of many beneficiaries there are still too many without prescription drug coverage. Given the fact that we all know about the problem, and I'd like to think by now we all know about the problem, need not really hear too much more about the problem, we must find a way to

help Medicare beneficiaries. However, I continue to maintain that we must do so in a manner that protects and strengthens Medicare.

While today's hearing will focus on strengthening and improving Medicare, we cannot design a benefit in a vacuum. We have to consider the impact that a new benefit will have in the long-term viability of Medicare.

We also must ensure that a new benefit does not discourage competition and the innovation that is the hallmark of the healthcare industry and the practice of medicine. I've always said that doctors and the medical industry are the magicians of our society, and we must construct policies that support the development of this wizardry.

In this context, as we do now under Medicare, we should continue to provide Medicare beneficiaries choices so they can select a program that best meets their needs.

Last, I want to make it clear, though, that while we have spent the past several years debating this issue, millions of Medicare beneficiaries have suffered from a lack of prescription drug coverage. I introduced legislation back in 1999 that would have provided immediate assistance to our poorest and sickest seniors. I never intended, and said so many times, for my bill to be a permanent solution, however, I did not have a lot of faith that we would be able to quickly work through this issue. Unfortunately, my fears were justified, and even though the House has passed comprehensive benefits in the past two Congresses some Medicare beneficiaries still don't have access to prescription drug benefits, and it's my hope that this changes in this Congress.

I'd like to again offer a warm welcome to all of our panelists and thank them for joining us today, and now I recognize Mr. Brown for an opening statement.

Mr. BROWN. Thank you, Mr. Chairman, and thank you all, you witnesses, for coming today.

The question you are being asked to consider is whether it would be better for seniors to get their drug coverage through traditional Medicare or through private drug plans. It seems like a silly question. Why would you force seniors and the disabled to buy one health benefit from a private company while receiving the rest of their coverage through Medicare Fee-for-service? The answer is, you wouldn't. The private drug plan approach is laughable in its right.

It all makes sense if goals other than fulfilling an unmet coverage need are being served. Proponents of private plans have been relatively forthcoming about some of these in the goals, less forthcoming about others. If pressed, they'll admit that private drug coverage is intended as an interim step leading to full Medicare privatization. They are less willing to acknowledge that Medicare privatization is itself a means to an end. Replacing traditional Medicare with a premium voucher is the easiest way to transform the program from a defined benefit to a defined contribution ending Medicare entitlement, ending Medicare as we know it.

Instead of acknowledging that ideology, the government programs always are bad, entitlements are bad, rather than acknowledging that ideology is driving the Medicare privatization campaign

proponents attempt to sell privatization on its own merits. I don't envy them that task.

It's difficult to justify dismantling a popular, reliable, cost-efficient public insurance program, so the Medicare beneficiaries can once again experience the pre-1965 uncertainty and volatility in the individual insurance market. Proponents tend to rely on vague assertions like the President's, Medicare should provide better help for its options like those available to all Federal employees. What does that mean exactly, traditional Medicare is more reliable and offers more choices than private health plans. Beneficiaries don't have to worry about disappearing coverage, their premiums and their cost sharing don't vary by county to county, by year to year, they can see the doctor and the specialist they trust, they can use the health care facility that best meets their needs.

Proponents of privatization say we need more choice, and Medicare Fee-for-service gives the ultimate choice. Medicare operates more efficiently than the private sector. For the past 30 years, Medicare has outperformed private insurance, even adjusting for coverage differences. Administrative costs have always been lower.

Perhaps, what the President actual means is that seniors and the disabled deserve better benefits, like those available through employer-sponsored coverage. That's certainly true, but neither the President, nor Republican leadership here, has proposed spending anywhere near the amount necessary to provide seniors drugs or preventive benefits comparable to those available in private health plans. Apparently, seniors deserve more options, just not any good ones.

Besides giving seniors better options, proponents say the private plan approach is a way of fending off prescription drug price controls. Just to clarify, the price a public purchaser like Medicare demands is a Draconian price control, the price a private purchaser, like an HMO, demands, is an all American discounted price per figure.

According to private plan proponents, Medicare price controls would jeopardize the drug industry's ability to conduct life-saving research and development. I think we all lose sleep at night worrying that the industry's high profits could plummet from obscenely high to unbelievably high. Yet, the proponents claim that private plans would secure lower drug prices for seniors than would the old tired Medicare program. Private drug plans would be better at controlling drug costs than traditional Medicare, they tell us, but the drug industry's future is in jeopardy if we go to traditional Medicare rather than through private plans. Clearly, something is wrong with this picture.

The President and the Congress, Mr. Chairman, should be concerned, in fact, should be concerned about the impact of Medicare prescription drug coverage on the industry that produces the drug. We also must be concerned about the impact on the Federal budget, not to mention the consequences for consumers and other purchasers if we do not confront spiraling prescription drug costs. We should bring these competing concerns out in the open and weigh them in a thoughtful manner.

So far, however, proponents of the private plan approach have denied that this approach promotes a status quo when it comes to

drug pricing. The most dangerous thing about the better option and lower prices rhetoric, upon which proponents of private plans rely, is that it obfuscates privatization's real goals and implications.

If the President and the majority want to end the Medicare entitlement, if they want to reduce Federal spending on Medicare by shifting costs to the beneficiary, they want to take a laissez-fare approach to drug prices, do nothing to constrain prices, they should be up front about it. The President and the majority think seniors deserve better options, I think they deserve the truth.

Mr. Chairman, I yield back my time. Thank you.

Mr. BILIRAKIS. Mr. Whitfield, do you have an opening statement?

Mr. WHITFIELD. Mr. Chairman, I'm going to waive my opening statement.

Mr. BILIRAKIS. Mr. Dingell, opening statement?

Mr. DINGELL. Mr. Chairman, thank you.

I commend you, Mr. Chairman, for holding this hearing, and I appreciate your courtesy to me and recognizing me.

Mr. Chairman, this is on a very important subject that we meet today, providing a prescription drug benefit for Medicare beneficiaries.

I want to thank our witnesses for being present today, especially Mr. Vladeck, who is not yet here, but for whom I have immense respect and high regard.

The Congress has spent a number of years debating how to add prescription drug benefits to Medicare. Everyone agrees we need to act, but there's a fundamental difference over how it is to be done. The gulf is not just over the stewardship of a prescription pharmaceutical program, but also over the stewardship of Medicare itself.

The issue at hand today is what role the government and the private sector should play in the delivery of prescription pharmaceutical benefits, and more broadly, in the Medicare program. I am very much concerned about the measure of the marketplace approaches taken by President Bush and my colleagues in the House amongst the Republicans, and what they would foist upon Medicare and Medicare recipients. We've made several forays into this area, and have found that we had some very significant hardships inflicted, and some very, very severe failures that we have undergone because of these efforts.

We often hear how the private sector is more efficient than Medicare, and, therefore, we should turn our seniors' healthcare over to private companies. History I think tells us very different, and I think that the seniors also tell us quite different.

I question whether the private sector is more efficient, and there are other concerns aside from efficiency that we should have at the forefront when thinking about Medicare—quality, equity, stability and compassion—something that private companies are not always in the business of providing.

I would note that excesses of the HMOs have been, quite frankly, recognizable best as not infrequently stupidity, and crass disregard of the well-being of their beneficiaries, or not infrequently just plain cold-hearted, flinty-eyed indifference to the needs of their patients, and abandoning hundreds of thousands of senior citizens who were silly enough to believe the promises that were made by

the HMOs, which got them in in the first place and out of regular Medicare.

I think it's not at all clear that private companies then are more efficient than Medicare. Even after adjusting for the coverage of comparable services, Medicare cost containment has been better than that of private insurance over the past 30 years. The record is very irrefutable. And, current evidence suggests that neither managed care nor competition are likely on their own to generate sufficient savings through efficiency to address the baby boom's coming retirement and the demands created by the growth in technology. And I think we better look at some of these claims, because they seem to have about the same reality as Alice in Wonderland.

If we want to reshuffle the future economic burden posed by demography, we should have a meaningful discussion on that very point. Those who do not agree we should honor our commitment to provide comprehensive affordable healthcare to our elderly and disabled should come forward and say so honestly, not engage in rather shabby misstatement of what they really intend, but come right flat out and tell us, this is what we want to do to the senior citizens. Those who believe this should then say it, and we should discuss how the elderly and disabled will meet their healthcare needs, and how their families, and especially their kids, are going to choose between taking care of their own kids and taking care of the needs of their parents.

But, people should not hide their true intentions under the guise of buzz words like competition and choice, because there are some simple yardsticks, how much does it cost and how much benefits can actually be delivered on an actuarially sound basis. These will tell us a lot more things than a lot of the pie in the sky that we are hearing on these matters.

These words are not infrequently, in fact, most commonly meant as euphemisms for limiting government assistance, shifting more costs onto seniors by forcing them into private insurance plans, and leaving plans that make key decisions about the seniors' coverage and out-of-pocket costs.

I would mention that the administration's plan for Medicare recipients is quite frankly, simply, to herd them all, reluctantly and involuntary into something called HMOs.

In any event, Mr. Chairman, I look forward to the hearing that you are going to have. I thank you for recognizing me, and I think we have a fine chance to explore what we are about to do today if we can get the truth out of the administration on these matters.

Mr. BILIRAKIS. The Chair thanks the gentlemen.

Ms. Wilson, for an opening statement?

Ms. WILSON. Thank you, Mr. Chairman.

I put my entire statement into the record, but I did want to highlight a couple of things I think are important.

When we add a prescription drug benefit to Medicare there are some principles that I'll be looking for and working toward. One is that it should be available to all beneficiaries. Second is that it has to be voluntary. There are a lot of people who have earned their coverage in other ways, either through a previous employer, or because they are eligible for prescription drugs through the VA for example.

I think that seniors do want choices, and I don't think there's anything bad about that word at all. My family gets their coverage from Loveless in Albuquerque. We like to get our medicine downstairs at the Loveless Pharmacy. I live in Santa Rosa, New Mexico, a long, long way from the nearest clinic. Perhaps, a mail order pharmacy is what I want, so that choices are a good thing to meet the individual needs of patients.

I also think that we need to give the most help to those who are low income and those who are very sick and have high medicine costs, and the plan that the House passed last year, under the leadership chairman, I think we did a pretty good job of that. In New Mexico, where we have large numbers of seniors who are low income, 64 percent of seniors in New Mexico would have qualified to pay only a $2 or $5 co-pay, and that makes a very big difference to seniors who are living in poverty.

In addition to creating this benefit, I think we have to look at innovative ways to reduce the cost of medicine, and certainly generic drugs have helped in that respect, but I also think we need to allow reimportation of medicine from FDA-approved facilities abroad. I know that's a controversial issue for some, but for someone from a border State it really isn't. In fact, I would bet anyone here donuts for breakfast on this bet, in Demming, New Mexico, a little town on the border of Mexico and the United States, I would bet anyone donuts that more people buy their penicillin in Mexico than they do in the United States. It's a whole lot cheaper and it is effective.

Finally, as we move forward on adding a prescription drug benefit to Medicare, we will have the opportunity for different elements of Medicare reform, and I think that the reform that is most needed in Medicare is that the system is fundamentally unfair in its reimbursement rates across this country. We no longer have a local market for healthcare providers. There is a national market for healthcare, and we continue to pay people differently based on where they live, with what they call the Physician Work Adjuster, which says that if you are a doctor practicing in Torrance County, New Mexico, your work isn't as valued by the Federal Government as if you were living in Dade County, Florida.

We don't pay into Medicare based on where we live, and we shouldn't be denied access to healthcare because of where we live.

Thank you, Mr. Chairman. I look forward to the testimony today.

Mr. BILIRAKIS. The Chair thanks the gentlelady, and, of course, without objection, the opening statements of all members of the subcommittee will be made a part of the record.

The Chair now recognizes Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

In the State of the Union Address in January, the President promised a prescription drug plan for seniors, but offered no specifics as to how this would be accomplished. The President didn't expand further, knowing full well that under his plan the 37-year Medicare program would, essentially, be privatized. His plan is based on the unpopular premise of forcing seniors into joining private plans. Whether it's an HMO or a PPO, these are the same plans that have said they don't want to cover seniors, and that have a pitiful record of providing seniors with healthcare.

The negative response from both Republicans and Democrats to the President's prescription drug proposal should have been a wake-up call to President Bush, that his Medicare privatization proposal would have a devastating impact on the health and security of our Nation's seniors. Seniors should not be forced to choose either a prescription drug benefit or their long-time doctor, and that's exactly what the President's plan would do, and, unfortunately, what it seems the GOP is also proposing.

Mr. Chairman, I'd like to express my opposition to privatization of Medicare as a means for achieving a prescription drug benefit. We are more than capable of providing a universal, dependable benefit that is under Medicare, which is exactly what the Democrats have proposed, and any other type of approach would be risky and destructive to a program that seniors need.

In my home State of New Jersey, we've been witnessing the effects of a privatized Medicare option. Nearly 80,000 New Jerseyans have lost their health coverage after their private HMOs concluded Medicare beneficiaries simply were not profitable. New Jersey's seniors also know all too well that private insurance companies are not willing to assist them with prescription drugs, and many seniors and HMOs nationwide say that prescription drug coverage is limited or the co-pay significantly increased, and I'm amazed that the President would ever believe his plan would not face a similar fate. That's exactly what would happen.

I think the time has come for Congress to add a meaningful prescription drug benefit within the Medicare program so we can strengthen the program with the addition of this critical benefit, while at the same time we preserve the stability and quality of the program to ensure that seniors have access to reliable health services.

Now, the Democrats have such a proposal. It's very similar to Medicare Part B, it pays your doctor bills, basically, provides for a voluntary $25 per month premium, $100 deductible, 80 percent of the costs paid for by the Federal Government, 20 percent co-pay, and most important requires the Secretary of Health and Human Services to negotiate prices so that prices of prescription drugs are brought down. There has to be a price component in whatever we do, in order to make drugs more affordable, otherwise we will continue to have major problems.

It's very simple to take up what the Democrats have proposed or something very similar to it. That's what we need, a guaranteed Medicare benefit that is voluntary and universal, people will have a choice that will be a meaningful choice.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. The gentleman's time is expired.

Mr. Rogers, opening statement?

Mr. ROGERS. Mr. Rogers will waive.

Mr. BILIRAKIS. Ms. Capps.

Ms. CAPPS. I will waive my opening statement and submit it for the record.

Mr. BILIRAKIS. Thank you.

Mr. Ferguson.

Mr. FERGUSON. Thank you, Mr. Chairman.

I want to thank you and members of the subcommittee and our witnesses for coming today and talking about a very important issue, our prescription drugs for our seniors.

Prescription drugs have helped seniors to live happier, and healthier and more productive lives. Few things that we do in this committee could be more important than crafting a proposal to bring the miracles of prescription drug medication to more seniors throughout our country. No senior should be forced between paying for food and shelter or the needed life-saving prescription drug medication which, literally, transforms the lives of millions of people in America and around the world.

It's tragic that over 1 million New Jersey seniors don't currently have prescription drug coverage. Health care security is a cornerstone to a secure retirement, and we must build on the significant progress that we made here in Congress last year to task legislation that would give our seniors that kind of security.

I look forward to working with you, Mr. Chairman, and other members of the committee on passing a generous and responsible package again this year. Any proposal that we consider before this committee has to, in my mind, accomplish some very basic, but important, goals, which we actually laid out last year. The plan must lower the cost of prescription drugs immediately, must guarantee coverage to all senior citizens under Medicare, must strengthen and improve Medicare with more choices and more savings, and also must strengthen Medicare for the future.

Last year, we did our work here in the House, we passed a strong bill, but the final product, of course, was elusive. This year, I hope this important legislation does not get bogged down once again.

I ask my colleagues on both sides of the aisle to come together to pass a responsible bill that will become law and will guarantee seniors the prescription drug benefits that they need.

I want to thank you, Mr. Chairman, for holding this hearing. I want to thank our witnesses for being here today. I look forward to working with you on this issue that's so important to our seniors, and I yield back.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Mr. Waxman?

Mr. WAXMAN. Thank you, Mr. Chairman.

It's been obvious for a considerable period of time, in fact more than a decade, that we need to add a prescription drug benefit to the Medicare program. That issue is not in doubt. Prescription drugs are a critical part of healthcare, and they are no less basic to a good coverage plan than hospital or physician services. And the senior population, the disabled population, who are part of Medicare are the highest users of prescription drugs, and they are the people who can benefit greatly from them. They are the people who are least likely, however, to have added a drug coverage, and seniors who are left trying to pay for their own prescriptions face the highest prices with no one to bargain for them. They are discriminated against in the prices they pay.

Coverage should be available to all beneficiaries, and the coverage should not be token coverage or used to discriminate against people who want to stay in traditional Medicare. It should be com-

plete coverage, similar to the coverage we provide in Medicare to other medical benefits.

There shouldn't be a hidden agenda. We shouldn't try to drive people out of Medicare fee-for-service. We should make a good drug benefit available to all beneficiaries, whether they choose to stay in traditional Medicare or elect to join a managed care plan. The point of covering prescription drugs should be to provide a healthcare benefit to people who need it, not to use it as either a carrot or a stick to push them into private insurance plans or managed care. Basic Medicare is a program that most beneficiaries prefer.

It amazes me that those who seem so enamored by competition as a model for our healthcare system are determined to give a competitive edge to private plans by refusing to put a good drug credit in the traditional Medicare plan. Are they afraid that the reform people want in Medicare is the addition of drugs to the basic program? Are they unwilling to admit that the choice beneficiaries are supposedly pulling out for is, in fact, a choice to stay in Medicare as they know it, with the addition of a good drug benefit? I believe the answer to both is yes.

So, I hope today we will concentrate on what should be the subject at hand, which should be, what should a drug benefit look like. And I believe the answer will be the same as what beneficiaries ask of all Medicare benefits: Make it available from the provider that they choose, cover the drugs their doctor prescribes, and make it affordable. It's really pretty simple.

Mr. BILIRAKIS. I thank you, Mr. Waxman, and I, too, hope that we will concentrate on the subject at hand, and that is, what drug benefits should look like. We all acknowledge the fact that the need is out there and the problems are there, so it's a matter of finding the solutions.

Let's see, Doctor Norwood.

Mr. NORWOOD. I'll yield.

Mr. BILIRAKIS. Thank you.

Where are we now? Let's see now, Mr. Allen is not a member of this subcommittee. If you'd like a 1-minute opening statement out of courtesy I'll be glad to give it to you.

Mr. ALLEN. Mr. Chairman, thank you. I will take this 1 minute, and I appreciate the opportunity to say just a few words.

I hope that in considering the Medicare benefit that would be appropriate for American seniors we look around the world and take some account of what the rest of the world does in this respect.

I would urge that we not shrink from dealing with the issue of price. Several members have said, on both sides of the aisle have said, it's important to reduce prices, and I would simply say that if we get too—if we believe that competition among buyers of prescription drugs will lead, as the night follows the day, to lower prices, I think we are mistaken.

It's vitally important that Medicare, that the Federal Government, have enough leverage over the sellers, over the pharmaceutical industry, in order to get the kind of prices that American seniors deserve.

And, with that, Mr. Chairman, I yield back and thank you for your courtesy.

Mr. BILIRAKIS. And, I thank the gentleman.

Mr. Upton.

Mr. UPTON. Well, thank you, Mr. Chairman. I appreciate your leadership on this issue for sure, and I was delighted to be a member of the House Leadership's Prescription Drug Task Force with the last two Congresses.

I have a full statement for the record, what I'd appreciate hearing from our witnesses today, particularly, as we look at the inequities in the current system, Medicare plus choice doesn't work in my district, doesn't work a lot in our State, and it really is unfair when you look at all of our seniors who pay taxes, and pay the Medicare premium, and yet, because we don't have Medicare plus choice in our district that other States and, obviously, thousands of people that benefit from better access and lower cost prescription drugs than they do in my district. And, how can we have equal access to drug coverage when, in fact, those inequities exist?

So, there are obvious flaws to the present system, and I'd be anxious to hear from the witnesses as we address that, and I will be in and out as we have a number of different activities this morning, but I look forward to coming back and asking those questions and yield back my time.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and I'll make a brief statement and ask that my full statement be in the record.

I want to thank you for holding the hearing on creating a Medicare prescription drug benefit. I think there's no other issue, other than conflict in Iraq, that's more important to me and my constituents than this one, and I'm sure that most of my colleagues feel the same way. After all, this Congress has debated the creation of Medicare prescription drug benefits for the better part of the last decade, our committees have had endless hearings on the issue, it was debated on the floor numerous times, we even had a long, all-night hearing last year. And, I know most of us have campaigned on it, and we still have not been able to reach an agreement on how best to design a benefit.

So, I look forward to the panel today. If you have some great words of wisdom that we haven't heard the last number of years, let me reiterate my support for providing some type of benefit under the traditional fee-for-service with Medicare, and that's where most of our seniors receive their healthcare from, through the fee-for-service, traditional Medicare, and we need to provide a benefit that's under that to make it effective.

And, I'll yield back my time.

Mr. BILIRAKIS. The Chair thanks the gentlemen. Opening statements of all members thus completed, and we'll get on to the panel now.

The witnesses include Doctor Dan Crippen, former Director of the Congressional Budget Office; Doctor Roger Feldman, former Senior Staff Economist for Health Policy and Economics on the President's Council of Economic Advisors, and currently Professor Health Insurance at the University of Minnesota; Mr. David Herman, Executive Director of the Seniors Coalition; Mr. Bruce Vladek, former HCFA Administrator, and currently Professor of

Health Policy and Geriatrics at Mt. Sinai University; and Mr. Erik Olsen, on behalf of AARP.

Gentlemen, obviously, your written summation will be made a part of the record, and we would hope that you would complement that as much as you might. I'll set the clock at 5 minutes, and we'll try to stay as close to it as we can.

Doctor Crippen, please proceed, sir.

STATEMENTS OF DAN CRIPPEN, FORMER DIRECTOR, CONGRESSIONAL BUDGET OFFICE; ROGER FELDMAN, PROFESSOR OF HEALTH SERVICES RESEARCH/POLICY, UNIVERSITY OF MINNESOTA; DAVID HERMAN, EXECUTIVE DIRECTOR, SENIORS COALITION; BRUCE C. VLADEK, PROFESSOR, HEALTH POLICY AND GERIATRICS, MT. SINAI UNIVERSITY; AND ERIK OLSEN, AARP

Mr. CRIPPEN. Mr. Chairman, Mr. Brown, members of the committee, once again, I benefit from having a last name that begins early in the alphabet.

I'm hopeful that I might be able to today put some context into these discussions very quickly. I'm not sure, in fact, probably sure the opposite is true, I can add any new words of wisdom, as Mr. Green suggested he was looking for.

There are few things in public policy that I've worked on, I think, more difficult to design than a pharmaceutical benefit for Medicare. Many elderly have insurance coverage today and access to drugs currently, but some, of course, do not. Retirees pay roughly 40 percent out-of-pocket for their drugs, compared to 33 percent for the non-elderly, and that may be too much in some cases. As with many other medical services, a relative few incur the lion's share of costs 25 percent of the elderly spend 65 percent of the total on drugs. But targeting a benefit to those most in need is very tricky and too wide a net will greatly increase Federal expenditures and likely place a greater burden on our kids and grandkids.

One place to start, Mr. Chairman, is an examination of the current use of pharmaceuticals by the elderly, as well as the source of funds for those purchases. Our public discussions are often framed in the objective of getting more drugs to the elderly, which is an admirable goal, but without fully considering who is paying now and who will pay under a new drug design.

This first chart helps illustrate the point. Fully 75 percent of the elderly, at least in 1999, and recognize that number may be changed some, fully 75 percent of the elderly have some form of insurance for drugs, although that number may be declining. Perhaps more important is that those with insurance fill an average of 32 prescriptions a year, those with private insurance fill 30 prescriptions a year, and the uninsured fill 25 prescriptions a year. While this gap between insured and uninsured, 32 versus 25, may imply that there are some elderly not receiving enough drugs, and surely some are sacrificing to pay, many elderly currently have access to pharmaceuticals.

The paramount issue, I would suggest, is "who should pay," both now and in the future-because much of what we are doing with virtually any drug benefit is shifting and moving spending that would

occur in the absence of a benefit. That may be good news or bad news, depending upon which side you are.

Now there may be good and compelling reasons to move current funding from the elderly and their former employers to current workers and taxpayers-perhaps a more uniform benefit, for example, but in so doing we need to recognize who is paying now and who will pay in the future.

In this light, a pharmaceutical benefit for the elderly may be both more and less daunting. I could easily construct a benefit that would cost $900 billion over 10 years-exactly half of what we expect the elderly will spend over that time period—a cost that many have deemed, of course, to be "too high." But much of that $900 billion is currently being paid by someone-it does not imply $900 billion in new spending for the economy. In fact, because most elderly are getting substantial pharmaceuticals now, some benefit designs could actually result in less spending overall in the Nation, but the payers will be different. Instead of the elderly paying as much of their own drug costs, current workers and taxpayers will pay more. Instead of retirees' former employers paying, all taxpayers will pick up some the tab. While these implications may not seem so great for current retirees and workers, surely my generation can afford to pay for drugs for our parents, the impact on future generations may be profound.

This second graph, Mr. Chairman, depicts current and future spending on existing Federal programs for retirees. Currently, we devote about 8 percent of our economy or 40 percent of the Federal budget to these programs today, but as my generation retires and we increase the number of beneficiaries from 40 million to 80 million we will more than double our obligations. Put another way, upwards of a fifth of what is produced in 2030—every fifth car, every firth shirt, every fifth loaf of bread—will be consumed by retirees from the resources transferred by just these three Federal programs.

These programs will consume roughly what we expend on the entire Federal budget today. In the extremes, to accommodate my generation's retirement, Mr. Chairman, we will have to either: borrow the equivalent of $1 trillion a year, something that's probably not sustainable for very long; virtually eliminate the rest of government as we know it, including education, defense, and all the rest; or, raise taxes by something like 8 to 10 percent of GDP. If it were in the form of payroll taxes, for example, something like a 35 percent combined payroll tax would be required to support all of these programs in the rest of government, as compared to 15 percent today. This portends an historic change in government and the economy in this country.

This graph, I would suggest, is also instructive on several other issues. Most important, there are only two moving parts here: the obligations and expenditures to the elderly and the size of the economy. So you can make retirement "more affordable" only by growing the economy or reducing obligations, not by shifting costs, stuffing mattresses or creating "solvent" trust funds.

We need to recognize that no matter what we do it is our kids who will be financing our retirement, whether through income

taxes, payroll taxes, whether we borrow from them, or whether we sell them a share of Microsoft out of our 401[k].

Thank you, Mr. Chairman.

[The prepared statement of Dan Crippen follows:]

PREPARED STATEMENT OF DAN CRIPPEN

There are few things more difficult to design than a pharmaceutical benefit for Medicare beneficiaries. Many elderly have insurance coverage and access to drugs currently, but some do not. Retirees pay roughly 40% out-of-pocket for drugs—compared to 33% for the non-elderly—and that may be too much in some cases. As with many other medical services, a relative few incur the lion's share of costs—25% of the elderly spend 65% of the total on drugs. But targeting a benefit to those most in need is very tricky and too wide a net will greatly increase federal expenditures and likely place a greater burden on our kids and grandchildren.

One place to start is an examination of the current use of pharmaceuticals by the elderly as well as the source of funds for those purchases. Our public discussions are often framed in the objective of getting more drugs to the elderly without fully considering who is paying now and who will pay with a Medicare drug benefit.

This first chart helps illustrate the point. Fully 75% of the elderly have some form of insurance for drugs, although that number may be declining. Perhaps more important is that those with insurance fill an average of 32 scripts a year—those with private insurance fill 30—and the uninsured fill 25 scripts a year. While this gap between insured and uninsured, 32 vs. 25, may imply that there are some elderly not receiving enough drugs, and surely some are sacrificing to pay, many elderly have access to pharmaceuticals.

The paramount issue, I would suggest, is "who should pay," both now and in the future—because much of what we are doing with virtually any drug benefit is shifting and moving spending that would occur in the absence of a benefit.

Now there may be good and compelling reasons to move current funding from the elderly and their former employers to current workers and taxpayers—perhaps a more uniform benefit or basic fairness. But in so doing we need to recognize who is paying now and who will pay in the future.

In this light, a pharmaceutical benefit for the elderly may be both more and less daunting. I could easily construct a benefit that would cost $900 billion over 10 years—exactly half of what will be spent even without a benefit—a cost deemed by most to be "too high." But much of that $900 billion is currently being paid by someone—it does not imply $900 billion in new spending. In fact, because most elderly are getting substantial pharmaceuticals now, some benefit designs could result in less spending overall in the nation than would occur in the absence of a benefit.

But the payers will be different. Instead of the elderly paying as much of their own drug costs, current workers and taxpayers will pay more. Instead of retirees' former employers (and by implication their current workers and shareholders) paying, all taxpayers will pick up the tab. While these implications may not seem so great for current retirees and workers—surely my generation can afford to pay for drugs for our parents—the impact on future generations may be profound.

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These programs will consume roughly what we spend on the entire federal budget today. In the extremes, to accommodate my generation's retirement, we will have to either: 1) borrow the equivalent of $1 Trillion a year; 2) virtually eliminate the rest of government, including education, defense, and all the rest; or, 3) raise taxes by something like 10% of GDP—if it were payroll taxes, something like 35% of payroll (from 15% now). This portends an historic change in government and the economy in this country.

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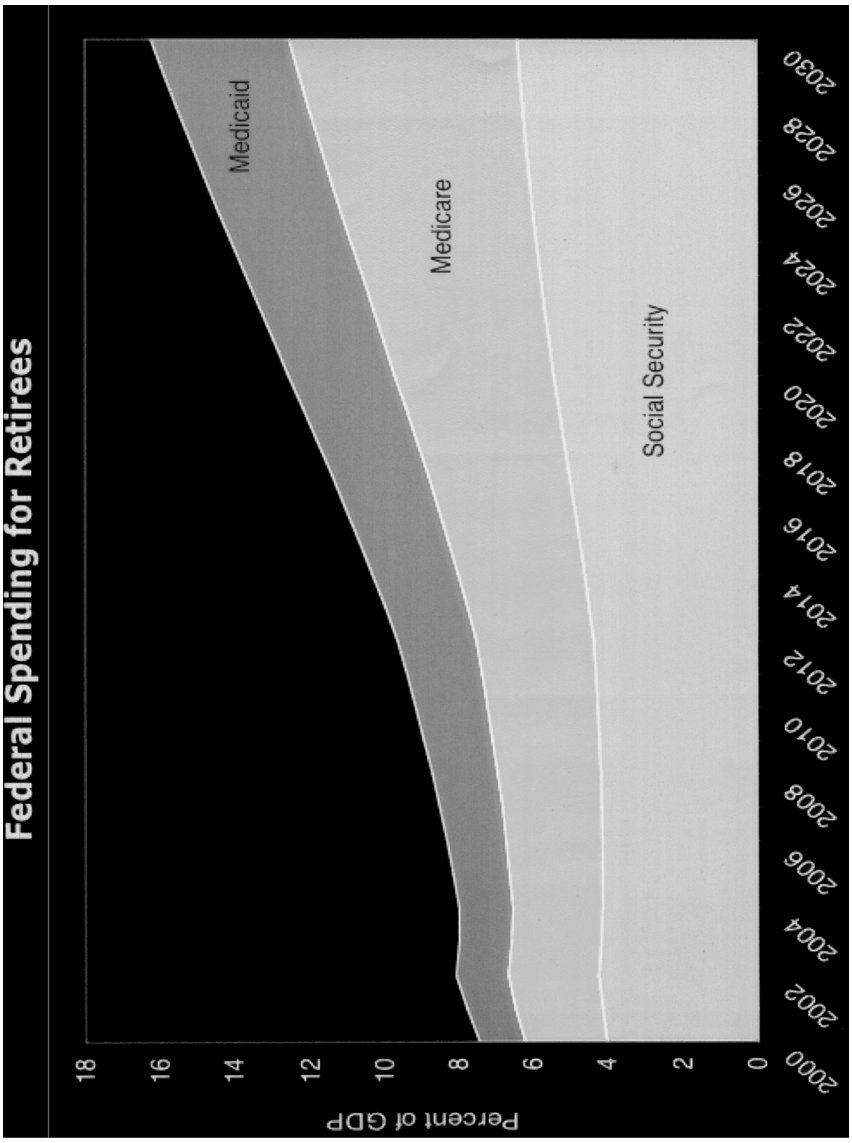
Medicare Beneficiary Drug Coverage, Use, and Average Price per Script By Type of Insurance Calendar Year 1999

	Number Benes		Ave. Scripts	
With Drug Coverage	30.2	75%	32	$45
Medicaid	6.4	16%	39	$40
Employer	11.9	30%	31	$55
Individual	4.5	11%	32	$41
Other Public	1.7	4%	37	$46
Medicare +	5.7	14%	28	$31
Without Coverage	10.1	25%	25	$37


Federal Spending for Retirees
Percent of GDP
18
16
14
12
10
8
6
4
2
0
2000
2002
2004
2006
2008
2010
2012
2014
2016
2018
2020
2022
2024
2026
2028
2030
Medicaid
Medicare
Social Security

Mr. BILIRAKIS. Thank you, thank you, Doctor Crippen. Of course, you haven't given us a solution.

Mr. CRIPPEN. No, only set the context so far.

Mr. BILIRAKIS. Doctor Feldman.

STATEMENT OF ROGER FELDMAN

Mr. FELDMAN. Mr. Chairman, and members of the committee, it is my pleasure to appear before you this morning, and possibly to offer some outlines for the solution.

In my opinion, the private sector should run a prescription drug benefit for fee-for-service Medicare, but the government has an important role to play here, too, and I will discuss that as well.

The private sector should run the program because it is better at discovering and implementing innovations to reduce the cost and improve the quality of drug benefits. An example of private sector innovation occurred in Minneapolis, Minnesota, where Blue Cross and Blue Shield educated physicians to increase their use of cost-effective drugs.

The private sector can adapt quickly when the need arises. In response to rising drug costs, many employers have introduced multi-tiered drug benefits. In contrast, changing the delivery of Medicare benefits for any reason has proven to be excruciatingly difficult. Congress actually blocked a demonstration of competitive pricing for Medicare M+C plans.

My next point is that Medicare beneficiaries should have a choice of drug benefit plans. Americans value choice, and having choices improves quality. Employers in Minneapolis found that technical quality of care improved when choices were introduced. Advocates of a single plan point to several supposed disadvantages of choice, including increased administrative costs, adverse selection, and the burden of protecting beneficiaries from the consequences of making bad choices. These criticisms don't stand up to close scrutiny.

The minimum size for low administrative costs in a drug benefit plan is several hundred thousand enrollees, so statewide or regional bidding areas would be large enough to offer choices with low administrative costs. Whenever beneficiaries have choices, the sicker ones may be more attracted to some plans than to others. Plans may try to avoid high risks by skimping on quality. However, it is useful to put this problem in perspective.

My colleagues and I recently found that M+C plans with drug benefits attracted enrollees who cost 3.6 percent more than average. If this difference is unacceptably large, it can be reduced by risk adjusting the payments to the drug plans.

The purpose of risk adjustment is to compensate plans that enroll high-risk beneficiaries. In my prepared remarks, I lay out the details of one such risk sharing arrangement, in which plans are paid more for enrolling beneficiaries with higher expected use of prescription drugs. This is not an ideal system. Ideally, I believe that all plans, including fee-for-service Medicare, should submit bids to cover all Medicare services. We proposed that system for the competitive pricing demonstration.

I am, however, confident that the government can run a competitive pricing system for Medicare drug benefits. Our experience in Denver proved conclusively that CMS could issue an RFP for a

complete package of Medicare services and evaluate the plan's responses in a very short time.

The last question raised by choice of drug benefits is whether the information load on seniors would be unbearably difficult. My position is simple, of consumers care about drug costs they will become informed.

My colleagues and I surveyed employees of Minnesota companies that switched from a single tier to a three tier drug benefit last year. Compared with employees in companies that kept their old single tier plan, they were more likely to know the correct price of new drugs. We also found that employees with more formal education were more likely to know that formularies, generic drugs, and mail order drugs have significant potential to reduce costs.

To educate seniors, the government can publish information on drug benefits and summary measures of consumer satisfaction, as it does for the Federal Employees Plan.

I've already argued that plans should bid on large regional areas, and I believe this would solve the problem of access for rural residents, which has so far plagued the M+C program. If local cost differences are discovered and Congress wishes to correct them, it can add explicit adjustment factors.

I want to conclude by saying briefly that the M+C program, although we love to hate it, has been successful in offering drug benefits to a majority, that is a choice of drug benefits in an M+C plan, to a majority of Medicare beneficiaries in this country.

Thank you for these remarks.

[The prepared statement of Roger Feldman follows:]

PREPARED STATEMENT OF ROGER FELDMAN, UNIVERSITY OF MINNESOTA

It is my pleasure to appear before you this morning to discuss a vital issue for the Medicare program: the provision of an outpatient prescription drug benefit for fee-for-service Medicare. For the past 20 years, I have studied the private health insurance industry from the vantage of a university researcher. From 1995 to 2000, I assisted the Centers for Medicare and Medicaid Services in designing a competitive pricing demonstration for Medicare. These experiences have been instrumental in shaping the ideas that I wish to share with you today.

As you well know, the Medicare entitlement provides only limited coverage of outpatient prescription drugs. This is in sharp contrast to private insurance plans that cover most Americans under 65. Virtually all analysts agree that prescription drug coverage should be part of Medicare. Without it, the elderly not only must spend unbearably large sums of money out-of-pocket for drugs, but they may forego cost-effective treatments. As President Bush said on March 4, "Medicare will pay a doctor to perform a heart bypass operation, but it will not pay for drugs that could prevent the surgery."

Despite this apparent consensus, it has been extremely difficult to fashion a Medicare drug coverage plan. Much of the difficulty centers on debate whether the program should be organized by the public sector through a single government-administered entity, or offered by the private sector through competing pharmacy benefit plans. In my opinion, this debate has polarized the discussion and has obscured the solution that we should be working toward. That solution includes both the public and private sectors. The role for private sector plans is to operate the drug program, and the government's role is to set the rules under which those private plans operate.

WHY THE PRIVATE SECTOR?

The private sector should run the program because it is better than the government at discovering and implementing innovations to reduce the cost and improve the quality of health insurance benefits. Let me describe one example of private sector innovation. As you know, pharmaceutical manufacturers have long promoted their products through the use of "detailing" representatives who visit physicians.

Blue Cross and Blue Shield of Minnesota, a not-for-profit health benefit plan, was concerned that detailing was not in the interest of patients, employers and insurers because it advocates the use of drugs with high profit margins at the expense of alternatives that might be less expensive and more beneficial. So within each drug therapeutic class, Blue Cross declared that certain drugs would be preferred, whereas others would be given a yellow cautionary flag and some would be deemed as red agents—the least cost effective. Blue Cross conducted classes for physicians and sent pharmacists to visit clinics with messages promoting the plan's favored drugs. Andrea De Vries, a student from our doctoral program at the University of Minnesota, found that there was a consistent increase in prescribing preferred agents among clinics with more pharmacist visits.[1] She concluded that it is possible to have a positive effect on drug utilization that is not driven by a financial incentive.

This example illustrates the private sector's ability to recognize a problem, devise a solution, and implement it effectively. Pharmacy benefit management (PBM) companies that run prescription drug benefit programs for most insured Americans under age 65 are another example of private sector innovation. PBMs control the cost of prescription drug programs by targeting the behavior of pharmacists, drug manufacturers, consumers, and prescribing physicians. One study found that PBMs obtained discounts of 13.2% below the average wholesale price of drugs, as well as manufacturer rebates of about 5%.[2] Researchers from the RAND Corporation reported that aggressive management through private PBMs has been shown to reduce drug expenditures by 15% or more.[3]

The private sector can adapt quickly when the need arises. For example, in response to rising drug costs, many employers have introduced multi-tiered drug benefit plans where employees have to pay more for non-preferred drugs. The use of "3-tier" pricing arrangements (lowest payment for generic drugs, middle payment for formulary or preferred brands, and highest payment for non-formulary brands) nearly doubled from 29% of covered workers in 2000 to 57% in 2002 according to a survey by the Kaiser Family Foundation.[4] An additional 28% of workers had "2-tier" drug benefits with a lower payment for generics and a higher payment for brand name drugs.

In contrast, changing the delivery of Medicare benefits for any reason has proven to be excruciatingly difficult. For example, I know of only one instance where the government has used its purchasing power to contract with selected providers for Medicare services. That is the demonstration of competitive pricing for durable medical equipment (DME). Congress actually used its power to block a demonstration of competitive pricing for Medicare M+C plans, despite the support of the CMS Administrator and a direct mandate from Congress to conduct such a demonstration.[5]

WHY MULTIPLE CHOICES?

A closely related question is whether Medicare beneficiaries should have a choice of pharmacy benefit plans. Advocates of a single plan point to several supposed drawbacks of multiple choice, including increased administrative costs, adverse selection, and the burden of protecting beneficiaries from the consequences of making bad choices.

Before dealing with these specific criticisms, let me say that choice of medical benefits should be good thing because Americans value choice. "One-size" benefits do not fit everyone. In the market for employer-based health insurance, for example, it has been demonstrated beyond a doubt that employers offer multiple health insurance plans because employees want to have choices.[6] Even countries with national

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[1] Andrea De Vries, "Affecting Physician Prescribing Behavior: Factors Influencing the Success of a Pharmacy Intervention," Ph.D. Dissertation, University of Minnesota, May 2000.

[2] David H. Kreling, "Cost Control for Prescription Drug Programs: Pharmacy Benefit Manager Efforts, Effects, and Implications," background report prepared for the DHHS Conference on Pharmaceutical Practices, Utilization, and Costs, Washington, DC, August 8-9, 2000.

[3] Dana P. Goldman and Geoffrey F. Joyce, "A Third—and Better—Way for Prescription Dug Coverage," *Los Angeles Times,* November 5, 2000.

[4] Kaiser Family Foundation, *Employer Health Benefits Survey, 2002 Summary of Findings*, http://www/kff.org/content/2002/20020905a.

[5] Bryan Dowd, Robert Coulam, and Roger Feldman, "A Tale of Four Cities: Medicare Reform and Competitive Pricing," *Health Affairs,* 19:5 (September/October 2000), pp. 9-29.

[6] Pamela B. Peele, Judith R. Lave, Jeanne T. Black, and John H. Evans III, "Employer-Based Health Insurance: Are Employers Good Agents for Their Employees?" *Milbank Quarterly,* 78:1 (2000), pp. 5-21; John H. Moran, Michael E. Chernew, and Richard A. Hirth, "Preference Diversity and the Breadth of Employee Health Insurance Coverage," *Health Services Research,* 36:5 (October 2001), pp. 911-934; and M. Kate Bundorf, "Employee Demand for Health Insurance and Employer Health Benefit Choices," *Journal of Health Economics,* 21:1 (January 2002), pp. 65-88.

health insurance systems allow some individuals to opt out (Germany) or to purchase private insurance when they need to fill gaps in the government plan (Britain and Canada).

Having choices also improves quality. An evaluation of a health insurance purchasing coalition operated by large employers in Minneapolis found that introduction of multiple choices (as many as 15 separate provider-controlled delivery systems) in 1997 was associated with improvement in technical quality of care for patients with diabetes.[7] Rates of use of preventive services either remained stable or improved after the introduction of choice.

What about the extra administrative cost of offering multiple choices? This is a true cost that can't be ignored. We know that large employers are more likely than small ones to offer multiple health insurance plans because they can spread the administrative cost over more enrollees. But it is easy to make too much of this problem. We could minimize the cost of buying automobiles if there were only one auto dealer in each city, and the administrative cost of grocery stores would be lower if there were only one of them. But we value choice of auto dealers and grocery stores quite highly, despite the extra administrative costs. Based on my discussions with a large PBM, I estimate that the minimum efficient size for low administrative costs is several hundred thousand enrollees. This estimate suggests that statewide or regional bidding areas composed of multiple states would be large enough to offer multiple choices with low administrative costs.

Whenever beneficiaries have multiple choices, the sicker ones may be more attracted to some health plans than to others. This phenomenon is called "adverse selection," and it can have implications for the efficiency of the health benefit program. Plans may try to avoid high risks by skimping on quality and cutting services that attract them. Adverse selection could be a problem for a multiple-choice prescription drug benefit in Medicare. However, it is useful (as it was for administrative costs) to put the problem in perspective. My colleagues and I recently completed a study of adverse selection in the M+C program, which will be published in the *Health Care Financing Review.* We estimated that M+C plans that offered drug benefits with an annual cap above $800 in 1999 attracted enrollees who cost 3.6% more than average.[8] This is an upper limit on the cost of adverse selection, because adverse selection from offering drug benefits at all has to be larger than selection from tinkering with quality and services once the benefit is offered.

THE ROLE OF GOVERNMENT

If this amount of adverse selection is unacceptable, it can be reduced further by "risk adjusting" the payments to the drug benefit plans. Risk adjustment means that payments are increased to account for the adverse selection experienced by a plan. A discussion of risk adjustment leads directly to the question of the government's role in a Medicare prescription drug plan. In my opinion, the government should set the rules for the program and make sure those rules are enforced.

One of the most important rules is how to share risk with the participating plans. As I understand the proposals currently on the table, the possibilities range from government bearing all of the risk except for the plans' fees, to the private sector bearing most of the risk subject to risk-sharing corridors. For example, plans might be at risk for a target level of spending, plus or minus 5%. If costs exceed the upper limit, the government pays the extra amount, and conversely plans keep the extra savings if costs are less than the lower limit.

Before discussing the details of my proposal risk-sharing proposal (which is only one among many), I want to emphasize that the purpose of risk bearing is to give private Medicare plans better incentives for cost containment. In order to accomplish this goal, as a general rule, private plans should bear the risk for events that they control, but they should not bear risk for events they do not control. In this context, private plans do not control the number of prescriptions that providers write within a therapeutic drug class. Thus, they should not be at full risk. However, private plans do control the choice of specific drugs to fill those prescriptions and the prices of those drugs. Thus, they should be at risk for the cost of drug management and drug prices. You could think of the cost equation as the product of three elements:

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[7] Alan Lyles, Jonathan P. Weiner, Andrew D. Shore, Jon Christianson, Leif I. Solberg, and Patricia Drury, "Cost and Quality Trends in Direct Contracting Arrangements," *Health Affairs,* 21:1 (January/February 2002), pp. 89-102.

[8] Roger Feldman, Bryan Dowd, and Marian Wrobel, "Risk Selection and Benefits in the Medicare+Choice Program," forthcoming in the *Health Care Financing Review.*

DRUG COST PER PERSON =
(1) NUMBER OF THERAPEUTIC PRESCRIPTIONS PER PERSON *
(2) SPECIFIC DRUGS USED TO FILL PRESCRIPTIONS *
(3) PRICES OF SPECIFIC DRUGS

To implement a payment system based on this formula, the government could specify the number of prescriptions in each therapeutic class that are written for a "standard beneficiary," who could be the average fee-for-service Medicare beneficiary for illustration. In a standard population of 1,000, there might be 50 prescriptions for ACE Inhibitors, 25 for Lipotriptics, and 10 for H2 Blockers per month. Using the preferred drugs on its formulary and its prices, a private plan might bid $100 per month to cover one standard enrollee. After all the participating plans have submitted bids, the government could use the bids to determine the enrollee's out-of-pocket premium contribution. For example, the government might pay 100% of the premium up to the higher of the median bid or the enrollment-weighted average bid, as we proposed for the M+C competitive pricing demonstration. Premium competition would provide powerful incentives for plans to submit low bids.

Next, enrollees would sign up for the drug benefit program. Because of the large subsidy (e.g., the government pays 100% of the premium of at least one plan), enrollment would be nearly universal, so adverse selection between enrollees and the general Medicare population would be minimized. Additional restrictions such as a penalty for delayed enrollment in the drug benefit program could also be imposed.[9]

After joining the program, enrollees would have an opportunity at regular intervals to select a particular private drug benefit plan, and the government would observe how many prescriptions were written in each therapeutic class for the plan's enrollees. This system requires the private plans to submit claims for each prescription, but that is their standard procedure for commercial business, so it is not an additional cost for them. If the plan that bid $100 for a standard enrollee attracts sicker beneficiaries who use twice the standard amount of prescriptions, it would be paid $200 per month. Because the plan is not at risk for the health of the enrollees it attracts, it does not have an incentive to skimp on covering drugs that attract them. However, if the plan overestimates its ability to manage the types of drugs used, or if it is overly aggressive in estimating its ability to get low prices, it must eat those extra costs.

This is not an ideal bidding system. Ideally, all plans, including fee-for-service Medicare, should submit bids to cover all services. Consumers could then choose among all plans based on premiums, amenities, and their preferences for the plans' medical management styles. We proposed that system for the competitive pricing demonstration, although the demonstration eventually was restricted to M+C plans only.

I am confident that the government—either CMS or a new, single-purpose agency—is technically capable of running a competitive pricing system for Medicare drug benefits. Our experience in Denver proved conclusively that CMS could issue an RFP for a complete package of Medicare services in a very short time, and it could evaluate the plans' responses. Bidding for one piece of the benefit package must be easier than that experience. Later demonstration efforts in Phoenix and Kansas City explored the design of formularies, co-payments for single- and multiple-source drugs, expenditure caps, and which prices to apply against the cap.[10] Solutions that were acceptable to the local stakeholders were found for all of those design issues.

The last question raised by multiple choice of drug benefits is whether the information load on seniors would be unbearably difficult, leading them to make bad choices. The main point I want to make is that the supply of information responds to the demand for it. If consumers have no reason to care about drug costs, then it follows that they won't demand information and they will remain ignorant. On the other hand, if they have a reason to care about drug costs, then there is a strong incentive to become informed. I know this from my own research, in which several colleagues and I surveyed employees of Minneapolis companies that switched from a single-tier to a 3-tier drug benefit last year. Compared with employees of companies that kept the old benefit, they were more likely to know the correct price of

[9] John M. Bertko, "Medicare Prescription Drug Plans: The Devil is in the Details," Washington, DC: American Academy of Actuaries, September 2002.

[10] For example, the local advisory committee in Phoenix decided that the average wholesale price (AWP) for brand name drugs should be applied against the benefit cap. They concluded that it was too difficult to include plans' discounts in the calculation because of large variations among plans.

new drugs.[11] We also found that more formal education was positively correlated with knowing that formularies, generic drugs, and mail order drugs have significant potential to reduce drug costs.

The second finding highlights the important role of education in informing consumers about drug costs. Our study looked at formal education, but there is also a role for specific drug education programs directed at seniors. The government has a major responsibility for providing those programs. Publishing information on drug benefits and summary measures of consumer satisfaction—as is done for the Federal Employees Health Benefits Program (FEHBP)—is an example of what the government can do for seniors. The FEHBP also encourages members to request generic drugs instead of brand name drugs and to use their plan's home delivery program if it has one.[12] The government could also require plans to provide on-line access to their formularies.

In addition to these information measures, the government could demand that sensible consumer protections be built into every plan. For example, although the bills under consideration are somewhat different, they all require private plans to include at least one and sometimes two brand-name drugs in each therapeutic class.[13] An appeals process can offer protection against arbitrary coverage denials. Finally, the patient's doctor can always write "dispense as written" orders.

THE BIDDING AREA AND URBAN-RURAL DIFFERENCES

I would now like to discuss two related questions that are very important in designing a Medicare drug benefit: Should plans bid on local or regional areas? And should there be adjustments for urban-rural differences?

The current M+C program allows risk-bearing organizations to designate service areas county-by-county (and even to select smaller areas if there is a significant geographic barrier to covering a whole county). Although there is some controversy around this definition, it makes sense for M+C plans to serve small areas because medical care markets are local. This is not the case for pharmacy benefit management. Prices that PBMs pay for drugs are determined by national volume, and utilization management techniques are national in scope as well. Because there is no distinct local market, it follows that the size of the bidding area should be determined by the minimum size needed to achieve economies of scale in administration. As I mentioned earlier, this might be at the statewide or regional level. Small states could be combined to achieve the critical mass needed for an efficient competitive bidding system.[14]

Bidding for large regions would solve the problem of access for rural residents, which has plagued the M+C program. Plans would have to cover all areas, both urban and rural, in the region. If the cost of dispensing drugs were higher for rural pharmacies than for urban pharmacies (although I know of no evidence that this is the case), then urban residents would implicitly cross-subsidize rural residents in the same bidding region. If local cost differences were discovered and Congress wished to recognize them, it could add an explicit adjustment factor to the payment system.

CONCLUDING OBSERVATIONS ON MEDICARE M+C

I would like to conclude with a few observations on the much-maligned M+C program, which has been accused by some of being unreliable and unstable.[15] The reason why some HMOs have withdrawn from the M+C program is that the payment system is seriously flawed. Instead of having HMOs tell the government how much it costs to provide Medicare services through a competitive bidding process, the government—which knows almost nothing about HMOs' costs—tells them how much it

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[11] Roger Feldman, Jean Abraham, Linda Davis, and Caroline Carlin, "Pharmacy Benefit Design and Consumer Knowledge of Prescription Drug Costs," Division of Health Services Research and Policy, University of Minnesota, April 2003.

[12] *FEHBP 2002 Guide,* United States Office of Personnel Management, www.opm.gov/insure. Home delivery enables members to get a 90-day supply of a drug instead of the usual 30-day supply, often at lower out-of-pocket cost per unit.

[13] H.R. 5019 requires that there is at least one branded drug in each therapeutic class; two, if the class includes more than one drug; or two and a generic, if available. S. 2625 requires the formulary to include all generics and at least one but no more than two branded drugs (with exceptions allowed if clinically inappropriate for a class). Other bills require unspecified "drugs within each therapeutic class."

[14] In a speech on January 23, Senator Max Baucus said that plans should be required to serve large geographic areas of at least two states. Montana's population of 140,000 seniors would have more options if the service area included multiple states.

[15] Public Citizen, "Proposals to Offer Drug Coverage Through Private Insurers and HMOs: A Step Backwards for Medicare," www.citizen.org/congress/reform/rx—benefits/drug—benefit.

will pay. Despite this flaw, the M+C program was still able to offer 391 separate products with some form of drug coverage in 2001.[16] 288 of those products had coverage limits that exceeded $800 per year, and 177 had unlimited coverage for generic drugs. The average premium for M+C products with drug coverage was $41 per month. Finally, about 54% of all Medicare beneficiaries had at least one drug-coverage M+C product available to choose in 2001. Therefore, although the M+C program is far from perfect, it has provided a choice of drug coverage for many Medicare beneficiaries, an accomplishment that has been beyond the ability of fee-for-service Medicare.

Thank you for allowing me to present these remarks.

Mr. BILIRAKIS. Thank you, Doctor Feldman.

Mr. Herman.

STATEMENT OF DAVID HERMAN

Mr. HERMAN. Mr. Chairman and members of the subcommittee, I am David Herman, Executive Director of The Seniors Coalition (TSC). On behalf of our organization and its 4 million members and supporters, I want to thank you for convening this hearing and for your continued interest in studying the best means for adding a much needed prescription drug benefit to the Medicare program, while preserving Medicare for today's beneficiaries and tomorrow's retirees.

We are grateful to you for this opportunity to present our findings about the needs and desires of seniors in the Medicare program, and our views on how best to meet those needs.

We all know that 21st century Americans consider prescription medicine coverage to be a crucial component in addressing their health insurance needs, but it is a fact that seniors need that component more than other segment of American society. Prescribed medication use increases with age and its associated chronic and acute health problems. Yet, only two-thirds of seniors have been able to address that need, and they are doing so at a great personal expense.

The remaining one-third of the senior population that does not have any prescription medicine coverage has no means of ensuring adequate health coverage and treatment. Uninsured seniors either do without their medication or they take reduced quantities, thereby reducing and nullifying the benefits. Eventually, this tactic can lead to deteriorated health and more invasive and expensive health treatment. This is a travesty on Medicare's original promise to provide seniors with the highest quality health care in the world.

The Centers for Medicare and Medicaid Services reported in 2002 that Medicare paid only 53 percent of the total cost of beneficiaries medical care. Who among us would purchase a health insurance plan that covered only 53 percent of our medical care costs?

In addition to coverage concerns, research conducted for the Seniors Coalition indicates that seniors key concerns for healthcare policy are: keeping healthcare affordable; providing healthcare access for everyone; free health wellness programs and illness protection; creating a prescription drug benefit for Medicare; strengthening financially the current Medicare program for the baby

[16] This information is courtesy of Rachel Halpern, a graduate student at the University of Minnesota. An M+C "product" is a benefit package with an associated premium and geographic service area. Since HMOs may offer more than one product, analysis of access to drug benefits in the M+C program at the product level is more accurate than simply looking at the number of HMOs that offer drug coverage.

boomers who will soon enter the program; and, Medicare is out of date and out of touch with the needs of today's senior citizens.

Solutions seniors can live with, it becomes obvious then from our research that all seniors need access to an affordable prescription medicine plan. They need changes and choices that take their varying financial and health status into consideration. They want an insurance plan that allows them to seek wellness care first, as opposed to illness treatment, and in keeping with this selfless legacy they want it strengthened for the next generation of beneficiaries, not just themselves.

In my full testimony, the Seniors Coalition addressed these needs in detail. I'd like to highlight those now and respectfully request that the subcommittee refer to my full testimony for greater depth and detail.

Our seniors desire that prescription coverage be made a core element of Medicare coverage through realistic legislation modeled on a market-based plan like the Federal Employees Health Benefits Program. To that end, our membership rallied to support H.R. 4954, the Medicare Modernization and Prescription Drug Act 2002, as an important first step toward such a market-based plan.

We believe there are certain safeguards that must be established in the prescription plans to ensure that seniors do not receive a substandard plan that will require changes within a few years. Specifically, we know that mandatory schemes imposed by Medicaid, such as prior authorization and preferred drug lists, are unacceptable limitations that can negate seniors' benefits.

Our research indicates such schemes can result in a systematic under-utilization of prescribed medications, which, in turn, can pose a threat to quality of care and potentially increase costs to the system.

Our research also indicates that seniors want a disease management component in their Medicare plan that will encourage and reward wellness and management of chronic diseases, and they want protection from long-term care costs which accounted for 41 percent of seniors out-of-pocket expenses in 1999. Non-solutions seniors can live without.

The most critical problem in consumer acquisition of needed medicine centers on price. The obvious culprits in the struggle to contain costs of needed healthcare are the brand name drug companies. While we realize we subject ourselves to criticism from those who make such attacks, we believe it is most important to the future of seniors' good health that we continue to uphold our free market system that is responsible for the remarkable products that such a system, and only such a system, encourages.

While we've been a vocal advocate against exploitive tactics by patent holders to unfairly extend patents and, therefore, disadvantage consumers, at the same time we're vigorous advocates for preserving the incentives for development of innovative therapies to address age-related chronic disease and physical disabilities attended to age.

Another suggested easy fix for the high cost of prescription drugs is drugs reimportation. Some have proposed that we simply establish a public policy that permits the importation of other government subsidized prescription drugs. Congress has previously re-

ceived testimony on the deadly effects of such actions, and the U.S. Food and Drug Administration has definitely declared they cannot validate the safety and efficacy of reimported drugs.

Our senior citizens want their own government, not foreign governments, to support and ensure their prescription coverage. When we compare the changes that have taken place in the health insurance business in the past four decades, since Medicare's inception, to the changes in Medicare there is no comparison. Medicare is pretty much the same one-size-fits-all plan that President Johnson initiated in 1965. Our seniors would like to see Medicare, the only insurance plan available to many of its 35 million senior participants, catch up.

Thank you.

[The prepared statement of David Herman follows:]

PREPARED STATEMENT OF DAVID HERMAN, EXECUTIVE DIRECTOR, THE SENIORS COALITION

Mr. Chairman and members of the Subcommittee, I am David Herman, Executive Director of The Seniors Coalition (TSC). On behalf of our organization and its four million members and supporters, I want to thank you for convening this hearing and for your continued interest in studying the best means for adding a much needed prescription drug benefit to the Medicare program, while preserving Medicare for today's beneficiaries and tomorrow's retirees. We are grateful to you for this opportunity to present our findings about the needs and desires of seniors in the Medicare program, and our views on how best to meet those needs.

SENIORS HAVE A DISPROPORTIONATE NEED FOR PRESCRIPTION MEDICATION

We all know that 21st century Americans consider prescription medicine coverage to be a crucial component in addressing their health insurance needs, but it is a fact that seniors need that component more than other segment of American society. Prescribed medication use increases with age and its associated chronic and acute health problems. Yet, only two-thirds of seniors have been able to address that need, and they are doing so by meeting Medicaid requirements, by continuing in private insurance plans through former employers, by enrolling in Medicare+Choice, or by purchasing Medicare supplemental insurance policies at additional personal expense.

The remaining one-third of the senior population that does not have any prescription medicine coverage has no means of ensuring adequate health coverage and treatment. They cannot afford supplemental prescription coverage, nor can they afford to pay for their prescriptions. To compound the problem, uninsured seniors do not receive a discounted price that insured seniors' insurance plans afford them. Uninsured seniors either do without their medications, or they take reduced quantities, thereby reducing or nullifying the benefits. Eventually, this tactic can lead to deteriorated health and more invasive and expensive health treatment. This is a travesty on Medicare's original promise to provide seniors with the highest quality health care in the world.

ACKNOWLEDGING MEDICARE'S PROBLEMS

In a survey published in June 2002 from Medicare's 1996-1999 beneficiaries, the Centers for Medicare and Medicaid Services (CMS) reports that Medicare paid only 53 percent of the total cost of beneficiaries' medical care. Who among us would purchase a health insurance plan that covered only 53 percent of our medical care costs? When prescribed medicines were considered separately, Medicare pays only 8.1 percent of all beneficiaries' cost, and that is inpatient prescription costs. CMS also reports that while those Medicare beneficiaries with drug coverage spend more on prescriptions than non-covered beneficiaries, the non-covered beneficiaries pay 75 percent more in out-of-pocket costs. In other words, those able to afford prescription drug coverage are also able to afford more medications, while those unable to afford prescription medicine coverage are forced to pay very high out-of-pocket costs to attain those medicines they can afford. This is upheld by CMS's data that shows that beneficiaries with prescription drug coverage fill more prescriptions than those without drug coverage, regardless of the number of chronic conditions they have. For example, CMS reports that among beneficiaries with five or more chronic conditions,

those with drug coverage filled 44.4 prescriptions, while those without drug coverage filled only 38.6 prescriptions. It has become abundantly apparent that Medicare's problem, the lack of a prescription medicine benefit, has become our seniors' burden.

We certainly applaud the efforts that pharmaceutical companies have made to make medicines more affordable to seniors through their discount card programs. These programs have allowed millions of seniors to access needed medicines they might otherwise not have been able to afford. However, the utilization by seniors of these programs highlights how important it is to enact broader real coverage for prescription drugs under Medicare so that all seniors can benefit from the solution we are presently working towards. Discount cards alone, whether from the private sector or the public sector, does not equal coverage and is not a solution.

That is not, however, the only problem our seniors experience in their Medicare coverage. In a survey prepared for TSC by The Luntz Research Companies, 42 percent of seniors listed the most important healthcare policy as keeping healthcare affordable, and the second most important healthcare policy as providing healthcare access for everyone. When asked to choose the specific Medicare benefit most important to them, 50 percent chose free health wellness programs and illness protection, and 43 percent chose creating a prescription drug benefit through Medicare. When asked to choose from several statements about Medicare two statements that they most agreed with, 55 percent agreed it was essential that we strengthen financially the current Medicare program for the baby boomers who will soon enter the program, and the second largest group agreed that Medicare is out of date and out of touch with the needs of today's senior citizens.

ADDRESSING THE PROBLEMS: SOLUTIONS SENIORS CAN LIVE WITH

It becomes obvious then from our research that all seniors need access to an affordable prescription medicine plan; they need changes and choices that take their varying financial and health status into consideration; they want an insurance plan that allows them to seek wellness care first as opposed to illness treatment; and, in keeping with their selfless legacy, they want it strengthened for the next generation of beneficiaries, not just themselves.

For many years The Seniors Coalition (TSC) has communicated to Congress our members' desire that prescription coverage be made a core element of Medicare coverage through realistic legislation modeled on a market-based plan like the Federal Employees Health Benefits Program (FEHBP). This is the same model that was recommended by the 1999 National Bipartisan Medicare Commission. To that end, our membership rallied to support H.R. 4954, The Medicare Modernization and Prescription Drug Act of 2002, as an important first step towards such a market-based plan. We support many of the provisions of this bill: A voluntary and affordable prescription program that provides permanent drug coverage while discounting medicines by as much as 60 percent to 85 percent; a reasonable deductible of $250, with protection against catastrophic drug costs by capping them at $3,800 per year; choice in plans that provides standard drug coverage or an improved benefit package to meet individual seniors' needs; safeguarding the private healthcare coverage that seniors already have; and, stabilization of Medicare+Choice;

In addition to those choices and changes, we believe there are certain safeguards that must be established in a prescription plan to ensure that seniors do not receive a substandard plan that will require changes within a few years. Specifically, we know that mandatory schemes imposed by Medicaid such as "fail first requirements," prior authorization and preferred drug lists are unacceptable limitations that can negate seniors' benefits.

Our research indicates that prior authorization schemes can result in the systematic underutilization of prescribed medications, which in turn can pose a threat to quality of care and potentially increase costs to the system in terms of avoidable emergency room and hospital admissions, physician visits, and nursing home stays. Medicines that seniors' doctors prescribe may not be available because of these mandatory schemes. This "one-size-fits-all" mentality is counterproductive to the findings of pharmacogenetics, or personalized medicine, which tells us that small differences between your genes and those of your relative or neighbor can affect how you react—or don't react—to a medicine. In an age when personalized medicine is becoming the promise of safer, more effective treatment, we would not want to see the government given a veto power that ignores the progress in genetic research in favor of their corporate gain. The long-term consequences to seniors could be grave. That's why we need to be able to choose among plans.

Our research also indicates that seniors want a disease management component in their Medicare plan that will encourage and reward wellness and management of chronic diseases. A successful disease management program has the potential to

enhance a patient's health outcome, control their disease, and avoid more invasive care while reducing overall health care spending. Yet, Medicare does not provide for sound coordination of care or disease management programs.

Another important protection that seniors need is protection from long-term care costs. A CMS study on 1999 cost and use by Medicare's beneficiaries showed that the majority of out-of-pocket spending was for Medicare cost-sharing and payment for non-covered services. Long-term care accounted for 41 percent of those expenditures. It is estimated that more than half of all seniors may need long-term care (LTC) during their lifetime, a statistical measure that points to the importance of making long-term care an affordable component of geriatric healthcare. The federal government, through Medicare and Medicaid programs, is the largest purchaser of LTC, with expenditures through 2020 projected to be $77.2 billion. Out-of-pocket expenditures for LTC are expected to be $35.6 billion by 2020, and it is estimated that "donated care" will climb to a value of at least $45 billion, and possibly as much as $94 billion.

In a detailed study on the problems with, and solutions to LTC, the Center for Long-Term Care Financing states that "the current crisis is dire. Somehow, the profession of long-term care must reduce its dependency on public financing, which drags like an anchor on profitability and quality of care. By some means or another, long-term care must attract more of the consumer-driven, private financing that will lift all boats."

Despite such warnings, few Americans are prepared for the financial apocalypse that long-term care ushers in. TSC supports legislation that encourages the purchase of private insurance through tax deductible long-term care insurance premiums and a tax credit for those with out-of-pocket long-term care expenses. We support legislation that is designed to protect seniors from the high and often financially devastating costs of long-term care by allowing a deduction for qualified LTC insurance premiums, use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long-term care needs.

THE PRICE CONUNDRUM

At its core, the most critical problem in consumer acquisition of needed medicines centers on price. The affordability of prescription drugs is a political hot-potato that seems to keep coming back year after year. You are all familiar with the heart-wrenching stories of seniors and economically fragile families, particularly those with young children, who cannot afford to purchase drugs that are prescribed by their doctors. We all know of seniors who are forced to make the choices I referenced earlier between buying food or their prescription drugs, or between the drugs and paying their rent or mortgage. It is the kind of dilemma that no senior should be caught in. The obvious culprits in the struggle to contain costs of needed health care, and the one who many well-meaning but plainly wrong senior advocates passionately attack, are the brand name drug companies.

Blaming brand name drug companies makes all of us feel better. Blaming brand name drug companies is the intoxicating elixir of choice for self-styled consumer advocates, and let's be honest—for many Members of Congress—for relieving the political headache brought on by high drug prices. However attractive the target, however pleasing the rhetoric may sound as it fills the airways, and however simple a solution it may seem, it is wrong.

Those who are hooked on the political elixir of blaming brand drug companies will immediately brand me as a biased advocate for the drug industry. That would be incorrect. The Seniors Coalition has been a strong critic of exploitation by brand drug companies of patent litigation for popular medications that effectively delays generic competition. We believe strongly that when a patent term runs its course, consumers have the absolute right to the benefits of a hotly competitive pharmaceutical marketplace. We therefore support the President's regulation that, once finalized, will prohibit patent holders to unfairly extend patents and thereby disadvantage consumers.

But we also are vigorous advocates for preserving the incentives for development of innovative therapies to address age-related chronic disease and physical disabilities attendant to age. It is our fundamental philosophy that seniors benefit from new drug breakthroughs that help seniors avoid costly and often debilitating surgery; new drugs that allow seniors to be mobile rather than trapped in wheelchairs or in convalescent beds; new drugs that allow seniors to live independently rather than in assisted living facilities; new drugs that allow seniors to enjoy the quality of life rather than suffering from one painful minute to another in a body incapable of normal functions; and new drugs that literally extend the lives of seniors who would otherwise be condemned to an early death.

The innovation that drives the development of such new drug therapies cannot, and does not, exist in a price controlled marketplace. Unfortunately, that is the remedy of choice now being seized by elected officials and regulators on both the state and federal level for high drug prices and the tool that is consistently applied by Medicare and Medicaid regulators. It is a solution that is so easy that it frankly seems too good to be true. It seems that way because *it IS too good to be true.*

I would ask you to look at the benefits of new drug research that have made real, quantifiable differences in the quality of life, and indeed the length of lives of seniors.

Over the past decade, pharmaceutical research companies have made dramatic advances in providing physicians more and more effective tools to treat disease. Between 1993 and 2002, 363 new drugs, biologics and vaccines that prevent and treat over 150 diseases and conditions were approved for marketing by the Food and Drug Administration.[1]

Let me describe a few of these advances that have impacted the quality and length of life of America's seniors:

Beginning in 1995, a string of major advances in the treatment of type 2 diabetes has allowed diabetic patients to more effectively manage their condition. Prior to 1995, there was only one category of medicines, aside from insulin, that were available to patients with type-2 (also known as non-insulin dependent) diabetes. Since that time, there have been five new classes of medicines developed, allowing doctors to better customize treatment regimens to fit their patients" needs. Because these medications have different mechanisms of action, and different side effects, combination therapy (using more than one type of medicine to treat the condition) can prevent patients from becoming hypoglycemic (having blood sugar levels that are too low), as well as prevent costlier complications, such as kidney problems.

Alzheimer's disease is a progressive disease that causes those who suffer from it to gradually lose their ability to remember things and to think clearly.[2] All four of the prescription medicines, belonging in two therapeutic classes, approved by the FDA to treat Alzheimer's disease have been developed in the past decade. Approximately three quarters of patients diagnosed with Alzheimer's disease are admitted to a nursing home within 5 years of diagnosis. As study of one cholinesterase inhibitor, rivastigmine, for treatment of mild to moderate Alzheimer's demonstrated improved cognitive function and a slowed rate of decline that delayed the move of patients to institutionalized care. Savings are realized in both the direct costs by delay of institutionalization and reduced caregiver burden. [H. Lamb and K. Goa, "Rivastigmine: A Pharmacoeconomic Review of its Use in Alzheimer's Disease," Pharmacoeconomics, 19 (2001): 3.]

These are just a few examples of the types of new, innovative medicines whose discovery and development would well have been delayed or eliminated completely in a price-controlled pharmaceutical market. Please allow me to stress our strong belief that the solution is not to attack this problem by limiting the ability of researchers to fund this continuing valuable new drug research, but a clearly more rational approach would be to develop appropriate public policies that will permit patients who need financial assistance to access these medicines.

The Seniors Coalition strongly repudiates price control schemes that have been and those that are being considered at both the state and federal level. Virtually all of these programs deny needed medicines to seniors; place patients at substantial health risk, including death; and deny seniors a quality of life that would otherwise be available if they had the financial means to pay for these needed medicines from their own pockets. That places seniors in a cruel public policy vise where they are denied access to medicines they desperately need today, and substantially limits the research for breakthrough drugs that would otherwise be available to them in the future.

America's seniors have been called the "greatest generation." The fruits of the sacrifice we have made are clearly evident. To call upon this greatest generation to now make the additional sacrifice of our health and well-being, to ask that we forfeit longer and more productive lives, to require that we not have access to medicines that would allow us to live independently and enjoy a quality of life would not just be a sacrifice, it would be a penalty on America's seniors.

We look forward to working with this Subcommittee to develop more responsible and effective public policies to preserve and protect the secure and healthy retirement years of America's seniors.

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[1] Pharmaceutical Research and Manufacturers of America, New Drug Approvals Series (Washington, DC: PhRMA, 1994-2003).

[2] National Institute on Aging, "Alzheimer's Disease Fact Sheet," February 2003 <www.alzheimers.org/pubs/adfact.html> (28 February 2003).

THE REIMPORTATION FIX

There is another seemingly easy fix for the high cost of prescription drugs. It is called reimportation. We simply establish a public policy that permits the importation of prescription drugs from one of our neighbors—the country of choice for many is Canada. We state that a consumer cannot be charged any more for those drugs that what a Canadian citizen pays. Drug costs in Canada are, for the most part, much lower than they are in the United States.

That is such a simple solution that it too seems almost too good to be true. Again, that is precisely because *it IS too good to be true.*

The primary reason Canadians can buy prescription drugs cheaper than we can in America is because Canada has a socialized medicine system that imposed strict price controls. So we are not really reimporting drugs into America from Canada, we are importing an economic policy that is antithetical to the free enterprise system we adhere to, and such policies undermine the American patent system that fundamentally recognizes the need for incentives for new drug development to assure a robust pipeline of new drugs in the future.

Then, of course, there is the serious problem of patient safety. The U.S Food and Drug Administration has definitely declared they cannot validate the safety and efficacy of drugs imported from Canada. The lack of regulatory controls in Canada, a country that is among the better of many of our neighbors, is well documented with pervasive contamination and counterfeit drugs.

CONCLUSION

The needs and desires of seniors might seem overwhelming if looked at as only a request for more spending on a growing senior population. But many, including the 1999 Bipartisan Medicare Commission, believe that increased competition through a variety of plans will make Medicare more efficient and save on its cost, while at the same time making Medicare more flexible and more responsive to beneficiaries' differing needs. Think of the changes that have taken place in the health insurance business in the four decades since Medicare's inception. Insured workers have gone from a one-size-fits-all plan to plans customized for specific family structures by particular industries. We have seen the addition and refinement of HMOs and PPOs, and we have seen the addition of tax benefits like MSAs and FSAs. The health insurance industry and the Congress have responded to the needs and desires of those they serve and made new products and new tax benefits available. But look at Medicare and what do you see? It is pretty much the same defined benefit, one-size-fits-all plan that President Johnson initiated in 1965.

Finally, think of the changes that have occurred in the senior population since the 1960s. We enjoy better health, we have 20 percent less disabilities than we did 20 years ago, we have a better overall quality of life, and we live a lot longer. We'd like to see Medicare, the only insurance plan available to many of its 35 million senior participants, keep up with us.

Mr. BILIRAKIS. Thank you, Mr. Herman.

Mr. Vladek. Welcome, sir.

STATEMENT OF BRUCE C. VLADEK

Mr. VLADEK. Thank you, Mr. Chairman, good morning, it's a pleasure to be back here yet again. We haven't always agreed on every issue, Mr. Chairman, but I've always been treated with the greatest courtesy and consideration by you and your colleagues on the committee, and a special appreciation to Mr. Brown in that regard, and I'm pleased to be here again today.

I have prepared a written statement, I hope that it can be put in the record, and I will try to be extremely brief in my comments this morning. I won't make the arguments for the need for a good prescription drug benefits for Medicare beneficiaries, many of the members have already done that more eloquently than I could, and I will not comment on specific proposals, since one of the luxuries of my current employment situation is I don't have to follow in detail all the current proposals.

But, I do think as we try, as you try to work this year to finally achieve a prescription drug benefit, it would be useful to think about some of the lessons and from the experience with the Medicare program over the last 35 years and some of the lessons that have been learned in the life of the program as principles to keep in mind in designing a program.

And, I think there are really five that are most important. The first is, the absolute importance of a benefit that is available to all seniors. I think we are all talking about a voluntary drug benefit, modeled on Part B. Once you have a payment involved, you need an opportunity for people to decline the coverage rather than have to pay the premium, but as I detail in my written testimony, unless the benefit is available on, essentially, equal terms to all beneficiaries you will create a web of inequities that I think is not otherwise soluble.

Second, I think the benefit needs to be a good benefit. I understand all the fiscal constraints and the tradeoffs, but the fact of the matter is that if you look at prescription drug expenditures by Medicare beneficiaries they occur across a wide range of income distribution in many different parts of the country, for people in many different kinds of circumstances, and the more sophisticated and the more elaborate we get in our design of caps, and "collars," and "donuts," and "donut holes" and what else one might call it, the more folks who are going to find the benefit a hollow promise that is of very little value to them, and the fewer of those with the greatest needs we are going to effectively cover.

In that regard, there's been a lot of talk with which I'm very sympathetic and with which I strongly agree in principle about designing special protections for low-income beneficiaries, I know in other instances this committee has spent a lot of time and effort on trying to protect low-income beneficiaries, and I would just cite one statistic in that regard. At the moment, despite vigorous efforts over the last several years, somewhere in excess of 40 percent of all the Medicare beneficiaries we believe are eligible for Medicare savings programs, for QMB or SLMB or QI1, QI2, are not enrolled, and in some States that number is as high as two thirds of beneficiaries. It's one thing to target this stuff on a chart in Washington to make up very fancy slides and graphs, it's another thing, as we've learned with the child health insurance program as well, to actually enroll people and keep them enrolled, and any efforts to target at low-income people our experience suggests are going to leave a lot of folks who have very significant needs outside the system.

Fourth, when we talk about the use of private plans and the employment of private plans in Medicare, I think we really have to look at the record, rather than rhetoric, and we do have 20 years of experience at paying private managed care plans in Medicare on a capitated basis, and I think there are a couple of conclusions one can draw in that regard.

The first is that in administration of a drug benefit all the things that Mr. Herman describes as undesirable, whether they are lists of approved drugs, or differential prices for different categories of drugs, or so forth, are things that managed plans need to use.

Second, I very much share the concerns of Mr. Upton and so forth about inequities in the existing Medicare+Choice system. We spent a lot of time on that in 1996 and 1997, if you'll recall, Mr. Chairman, I would argue that in a capitated or any fixed price, private competitive system those problems are inherently insoluble without incurring enormous additional expense for the program, and I'd be happy to expand on that further in the course of the discussion.

Finally, there's always sort of the notion that by giving private plans responsibilities for certain administrative functions, Congress or the executive branch can somehow be off the hook from difficult decisions about who gets covered and how. I think that's not been our experience, you just have a different set of problems that you have to worry about.

I've already exhausted my time. Again, I appreciate the opportunity to be here this morning and I thank you again, Mr. Chairman.

[The prepared statement of Bruce C. Vladek follows:]

PREPARED STATEMENT OF BRUCE C. VLADECK, MOUNT SINAI SCHOOL OF MEDICINE

Mr. Chairman, Mr.Brown, Members of the Subcommittee, my name is Bruce C. Vladeck. I am currently Professor of Health Policy and Geriatrics at the Mount Sinai School of Medicine in New York City, and engaged in a number of other activities in health care, including Chairmanship of the Board of a developmental, pre-PACE, Medicaid managed care plan for the frail elderly. As you know, I was Administrator of the Health Care Financing Administration from 1993 to 1997, and subsequently served as a Presidential Appointee along with Mr. Bilirakis and Mr. Dingell on the Bipartisan Commission on the Future of Medicare. It is a pleasure to have the opportunity to appear before you again. While we have not always agreed on every issue, I have always been treated with the greatest of courtesy and consideration by you, Mr. Chairman, and the Members of this Subcommittee, and I very much appreciate the opportunity to renew those acquaintances.

I will not take much of your time this morning describing the importance of a prescription drug benefit for Medicare beneficiaries. I believe that, by now, the necessity of such a benefit is almost universally acknowledged, as is evidenced not only by the Members' opening statements today but by the range of proposals already being considered by this Congress. To me, it continues to be rather astonishing that, at this juncture in our history, some ten million senior citizens of the world's wealthiest nation lack even the most basic coverage for the costs of prescription drugs that might prolong their lives, reduce pain and discomfort, or prevent disability. But I am hopeful that, through the work of this Subcommittee and your colleagues in both Houses of the Congress, 2003 might finally prove to be the year in which a worthwhile, effective benefit is enacted.

I will also not take up your time this morning commenting in detail on any specific proposal for a Medicare prescription drug benefit. One of the great advantages of my current circumstances is that I no longer need to remain current with all of the details of specific proposals, and I hope and expect that the legislative process before you is one in which useful concepts and innovative ideas from a variety of different sources will ultimately be melded into final legislation. Instead, given my perspectives and my experience, I thought the most useful thing I could do today would be to describe and comment on a handful of issues and themes that I think must be adequately taken into consideration in order to craft a Medicare drug benefit that will meet the needs of beneficiaries, make administrative and fiscal sense, and not hold out a promise to the nation's disabled and senior citizens which their government is then unable to fulfill.

Specifically, I think there are five critical points that must be considered:

First, a Medicare prescription drug benefit must be universal.

This is a large and heterogeneous country, and Medicare beneficiaries are a diverse and heterogeneous group. Their needs—including their needs for prescription drugs—vary from one individual to another, and for individual beneficiaries over time. Further, while those needs are strongly correlated with socioeconomic and health status, they are not perfectly and uniformly connected to them. For example,

nearly half of Medicare beneficiaries who lack adequate prescription drug coverage have incomes in excess of 200% of the federal poverty level. So any benefit designed to cover only part of the Medicare beneficiary population or only part of their costs will invariably exclude at least some people who really need it; will create inequities across geographical, social, and disease groups; and will unavoidably create a series of notches or boundaries which will invariably create resentment and perceptions of unfairness—not to mention significant headaches for the Congress in the future.

Medicare's universality is one of its greatest strengths—both in terms of popular support and simple administrative practicality. Virtually every individual eligible for the program is enrolled, and once enrolled, they receive the same level of Medicare-funded benefits regardless of age, income, residence, or delivery system choice. Dr. Karen Davis, President of the Commonwealth Fund, has recently produced some estimates of the overall costs to the American health care system of the very fragmentation and decentralization of our health care system. Whether one agrees with every aspect of Dr. Davis's analysis or not, the underlying point is that universality simply takes off the table what is otherwise the source of considerable complexity, confusion, and expense.

As the history of Medicare Part B over more than thirty-five years well demonstrates, one can have a universal benefit for which enrollment is voluntary. Every contemporary proposal for a Medicare prescription drug benefit that I have seen calls for such voluntary enrollment, and I agree that it is essential that beneficiaries have the option of declining a drug benefit for which they would have to pay an additional premium. But I would also remind the Members of this Subcommittee that, of all the possible insurance benefits for services heavily used by Medicare beneficiaries, insurance for prescription drugs is especially susceptible to adverse selection—a phenomenon that has already priced Medigap policies that cover prescription drugs out of the market in most of the country. This adverse-selection problem also helps explain the concerns that so many have raised about a stand-alone drug benefit. Designing a prescription drug benefit that really works for Medicare beneficiaries will therefore require setting a premium level low enough to maximize enrollment, and thus avoid self-selection by high-risk beneficiaries.

I am also aware that roughly one third of Medicare beneficiaries currently receive prescription drug coverage through employment-related retiree benefits—although that proportion is expected to fall steadily in the coming years—and that it would be highly desirable, both for beneficiary convenience and federal fiscal purposes, to keep as many employers in the game as long as possible. There are a variety of ways in which employers could be given financial incentives to maintain such benefits, and so long as the net costs of the subsidies is no greater than direct Medicare coverage would cost, I would think we should want to do so.

Second, a Medicare Prescription Drug Benefit Must Be a Meaningful Benefit

In an understandable effort to minimize program expense or hit some sort of arbitrary budgetary target, many proposals for a Medicare prescription drug benefit have contained complex combinations of variable coinsurance, "collars," "caps," and "donuts," to precisely define the relative shares to be paid by insurance and coinsurance at each level of beneficiary drug expense, and in many instances as well to target insurance benefits on certain sub-categories of beneficiaries. Yet many of those efforts run counter to the basic underlying realities of Medicare beneficiaries and their expenditures for prescription drugs. About one third of Medicare beneficiaries spend $500 a year or less on prescription drugs; another ten percent spend more than $6,000. But the majority of beneficiaries are pretty evenly distributed across intervening levels of expenditure, with the average for all beneficiaries being somewhere between $2,500 and $3000. At the same time, the median Medicare beneficiary living alone has an income of roughly $15,000 a year, and will be paying close to $800 of that for Part B premiums in 2004; the median couple, with an income of slightly more than $25,000, will pay $1600 in premiums. Assuming that any new drug benefit will carry an additional premium and some form of coinsurance, it's clear to me that any additional holes in coverage, above ordinary coinsurance, will vitiate the value of the supposed benefit for many beneficiaries, and leave us right back where we started in terms of the inability of beneficiaries to afford the drugs they need.

Third, We Shouldn't Fool Ourselves About the Ability to Target Lower-Income Beneficiaries

Cognizant of the extremely limited incomes of many Medicare beneficiaries, the authors of most of the proposals for a Medicare prescription drug benefit currently being discussed have sought to provide additional protection for low-income beneficiaries, through lower premiums or coinsurance or both. Some proposals have ex-

tended prescription drug benefits to lower-income beneficiaries only. I certainly share the belief that lower-income Medicare beneficiaries not currently eligible for Medicaid are desperately in need of assistance in paying for prescription drugs, and I am sympathetic to efforts to tilt the design of any benefit structure in favor of those with lower income, but I think it's critically important that we not deceive ourselves about our ability to target benefits nearly as precisely as we would like.

First, it's important to remember that something like 40% of all Medicare beneficiaries live in households with incomes below 200% of the federal poverty level. For some of those households, Medicaid currently provides prescription drug coverage, but that still leaves perhaps eight to ten million beneficiaries with low incomes and limited coverage, if any, for prescription drugs, while millions more with incomes just slightly above that level also have very limited financial resources. So even relatively narrowly-targeted coverage will still cost a substantial amount of money while leaving many beneficiaries with very real needs uncovered.

Second, many of you will remember from our discussions of income-related premiums during our work on the Balanced Budget Act the basic fact that neither the Centers for Medicare and Medicaid Services nor the Social Security Administration maintains any income information on beneficiaries, other than that which is obtained from sample surveys. The only comprehensive data on income of individual Medicare beneficiaries is that maintained by the Internal Revenue Service, and even that is extremely incomplete, since almost half of the elderly population has insufficient taxable income to require filing of income tax returns. IRS data, of course, is also retrospective and lagged; some time this coming summer, we will have information on the 2002 income of roughly half of beneficiaries. Thus, any prescription drug benefit in which premiums, coinsurance, or benefits vary by income will require creation of an entirely new administrative apparatus, or reliance on existing State Medicaid agencies or, in a few instances, other State agencies that do income determinations for state-operated pharmaceutical assistance plans. This is not just a problem of bureaucratic complexity or expense; as our more recent experience with the SCHIP program has taught us all too well, effectively reaching individuals who are legally eligible for publicly-subsidized health insurance benefits requires a systematic investment of administrative commitment, time, and resources.

In short, policy proposals for income-related targeting that look extremely elegant on the spreadsheets and PowerPoint presentations of Washington policy analysts are often highly inapplicable in the real world. This is not just a theoretical problem; we only have to look at the experience of the Medicare Savings Programs to recognize that, even under the best of circumstances, benefit programs that require specialized outreach and income-eligibility determinations are extremely unlikely to reach all who should be able to benefit from them. Under the most recent estimates, for example, more than 40% of Medicare beneficiaries eligible for SLMB/QMB benefits are not enrolled, and in some states that proportion exceeds 60%. What should also be recognized, in addressing the problems of low-income Medicare beneficiaries, is of course the interaction with Medicaid. States are now spending some $13-15 billion a year on prescription drug benefits for dually-eligible Medicare-Medicaid beneficiaries, of which $5-6 billion is their own tax-levy money, with the balance being federal match. Even a relatively modest, universal Medicare prescription drug benefit would thus generate very substantial savings for the states, at a time when fiscal relief is desperately needed. Conversely, even with all of the fiscal pressure on state Medicaid budgets, it is not hard to envision building into Medicare prescription drug legislation some expectation of continued Medicaid wrap-around coverage not only for beneficiaries for whom Medicaid is currently paying the whole bill, but for a somewhat expanded pool of low-income beneficiaries in addition. Such an approach would be particularly desirable because the actual benefits provided under Medicaid are far superior to those offered by even the most generous Medicare prescription drug benefit proposals now before the Congress.

Fourth, the Design of a Medicare Drug Benefit Should Be Grounded in Actual Experience with Private Health Plans, Not Rhetoric or Special-Interest Pleading

For those of us who participated in the debates leading up to the enactment of the Balanced Budget Act in 1997, the current preoccupation with the potential role of private plans in provision of a Medicare prescription drug benefit can't help but generate a disconcerting sense of dejà vu. I am also reminded of the old adage about second marriages: that they represent the triumph of hope over experience. For while much of the rhetoric about the potential role of private plans is essentially unchanged from what we heard five or six years ago, we now have another five or six years' worth of actual experience from which we can deduce some pretty clear-cut conclusions.

Private managed-care plans have participated in Medicare throughout its history, and significant participation by private plans paid on a capitated basis has now been going on for almost twenty years. We have a lot of actual experience, and a lot of data. While analysts can argue ad infinitum about almost any point that has ideological or political implications, I believe that several conclusions from that experience are crystal clear:

1. To date, participation of private plans in Medicare has yet to save the Medicare program a nickel. Prior to the BBA, Medicare's rate methodology, interacting with favorable risk selection for the plans, produced payments to private plans significantly in excess of what Medicare would have paid had those beneficiaries remained in fee for service. Changes in the payment formula contained in the BBA, along with the fact that private sector costs have increased much more rapidly than those in Medicare FFS, have largely eliminated this phenomenon by now, but have also driven many plans out of the program.
2. Even if one could establish a perfectly "level playing field" in payments between Medicare fee-for-service and private plans, private plans would still incur marketing, enrollment, and administrative costs (in addition to any possible profit) that don't affect "traditional" Medicare. In order to provide precisely the same services at the same costs, therefore, private plans have to either be at least 15-20% more efficient in their use of services than Medicare, or else extract prices from providers lower than those Medicare pays, something that was quite prevalent before the BBA, but that is no longer possible in most communities. While private plans are often more economical in their use of services than the traditional system, documented evidence of a 15-20% differential is extremely hard to come by.
3. Thus, historically, private plans have been able to provide additional benefits to Medicare beneficiaries without additional premiums only when they were overpaid.
4. When private plans are not happy with Medicare payment levels or other environmental conditions, they leave the program. They also leave as a side-effect of continuing consolidation, reorganization, and corporate restructuring in the private health insurance industry. One should hardly expect anything different from private, for-profit firms, but the effect of such departures on beneficiaries can be quite significant. Plan turnover certainly raises significant issues about continuity of care for beneficiaries. It should also be emphasized that the widespread withdrawal of private plans from Medicare in 2001 and 2002 was hardly unprecedented: a proportionately similar number of plans withdrew in the late 1980s.
5. In general, managed care plans are much more prevalent, and much more successful, in urban than rural areas. Few rural communities have the kind of oversupply of providers that gives managed care plans their greatest leverage over prices and patterns of care, and marketing and enrollment costs per beneficiary are much higher in rural areas.
6. The data are also quite clear, and consistent over the past fifteen years, that the overwhelming majority of the small minority of Medicare beneficiaries enrolled in private plans are highly satisfied with the choice, while the overwhelming majority of those who have chosen not to enroll in, or who have left, private plans are also highly satisfied with Medicare, and don't want to enroll in private plans. One would hardly expect anything different. Nor is it surprising that Medicare beneficiaries, in general, are substantially more satisfied with their health insurance than enrollees in private plans who are denied the opportunity to make those kinds of choices.
7. Finally, as those private plans that have remained in Medicare + Choice over the last several years have sought to adjust their benefit and premium structures to survive economically in a more difficult and rapidly-changing market, they have come up with a variety of limits, coinsurance arrangements, and premium structures for their prescription drug coverage that make inter-plan comparisons increasingly difficult to describe, let alone making the choice process more difficult and confusing for beneficiaries.

In sum, whatever the rhetoric may be, I think the data concerning the participation of private plans in Medicare leads unavoidably to the conclusion that, for a minority of beneficiaries, when payment levels and benefit structures are roughly equivalent with the fee-for-service program, private plans can produce some benefits—although cost savings are clearly not among them. Requiring beneficiaries to enroll in private plans in order to obtain affordable prescription benefits, on the other hand, would be inherently inflationary, would discriminate against rural beneficiaries and those in other low-managed care markets, would make a lot of bene-

ficiaries very unhappy, and would cause considerable administrative and political turmoil when market exigencies induced lots of plan exits.

Fifth, No Matter How Much Privatization is Involved in Construction of a Medicare Prescription Drug Benefit, There Will Still Be A Complex, Unavoidable, Difficult Federal Role

One of the great attractions of private managed care for purchasers both public and private, I've long believed, was the illusion that turning health insurance functions over to private plans would reduce the burden on purchasers of making difficult decisions about coverage, benefit design, and access to care. But both employers and legislators have learned that it's not so easy to get off the hook; the same problems come back in new forms.

Widespread participation by private plans in the delivery of a Medicare prescription drug benefit, for example, might produce considerable variation in benefit design, formulary composition, substitution policies, and customer service strategies, but if Medicare beneficiaries throughout the country are to receive relatively uniform benefits and relatively equal access to needed drugs, and if there is to be sufficient accountability in the expenditure of public funds, then the more participation there is by private plans, and the more freedom they are given in benefit design and administration, the more formidable the federal standards-setting and monitoring task will be. Unless private plans were required to cover every drug listed in the US Pharmacopeia with uniform coinsurance, the opportunities for manipulating formularies, appeals mechanisms, and/or tiered coinsurance levels to achieve favorable risk selection are so substantial and so pervasive that uniform national policies will be unavoidable, and someone will have to not only figure out how to establish them, but how to enforce them. Marketing practices and public disclosure issues pose similar challenges. And as the growing volume of litigation around PBMs suggests, ensuring program integrity in an industry in which rebates, proprietary pricing information, and sophisticated, complex, promotion schemes are widespread will also require considerable effort by the federal government.

Indeed, given the history of the pharmaceutical insurance and distribution industries over the last decade or so, I think it's no exaggeration to suggest that widespread participation by private plans in delivery of a Medicare prescription drug benefit would leave the Congress with a policy choice between a highly regulated private "market" and a scandal waiting to happen. Either of those alternatives is likely to be more expensive, in the aggregate over time, than a uniform benefit directly administered by government contractors through well-established, existing mechanisms.

In summary, I think that there are many who believe that we now have an historic opportunity to enact a real, effective, administrable prescription drug beneficiary that will provide critical access to needed pharmaceuticals for millions of Medicare beneficiaries, ease the financial burden on millions of hard-pressed families, and make available to Medicare patients and their health care providers the full armamentarium of modern medicine, with all the benefits that can produce. But I very much hope that we can get it right the first time; that our policies will be guided more by realism and experience than by theories or ideologies—no matter how seductive some of those might be; and that we do our best to avoid policies or processes that are bound to fail.

Again, it's been a pleasure and a privilege to have the opportunity to appear before you again, and I'd be delighted to try to respond to any questions you might have.

Thank you very much.

Mr. BILIRAKIS. Thank you, Mr. Vladek.

Mr. Olsen, please proceed, sir.

STATEMENT OF ERIK D. OLSEN

Mr. OLSEN. Mr. Chairman and members of the subcommittee, my name is Erik Olsen. I am a member of AARP's Board of Directors. On behalf of our 35 million members, I want to thank you for including us in this discussion of how to design a Medicare drug benefit. A meaningful and affordable Medicare drug benefit remains a top priority for AARP. As a Medicare beneficiary myself, I can tell you personally about the importance of drug coverage. Yet, despite the promise of relief, older and disabled Americans continue to face

double digit increases in both drug spending and fewer options for coverage, through employers or managed care.

Our members and their families are counting on your leadership and action for this year. Our members also tell us that a Medicare drug benefit should have several key features.

It should be available to all beneficiaries, whether they choose traditional Medicare, managed care, or a new coverage option.

It should be stable to provide coverage that we can rely on from year to year.

It should provide extra help for people with low incomes.

It should protect those with the highest costs, and moreover, it should not create more incentives for employers to drop current retiree coverage for disadvantaged beneficiaries in the traditional Medicare program.

More specifically, we have learned from research we conducted with AARP members and the general public that acceptable premiums should be no more than $35 a month. A $6,000 catastrophic cap is generally viewed as too high to provide real assistance.

Benefit designs that have gaps in coverage are viewed negatively. Some believe drug coverage should be linked to fundamental changes in Medicare. AARP does believe there is room for some improvements in Medicare. We support sensible improvements, as long as they start with drug coverage and they would not put the traditional fee-for-service program and the millions of beneficiaries who rely on it at a disadvantage.

We also urge you to consider the following in designing a drug benefit. It should promote safety and quality, and be integrated into the program, so it can foster better care management for chronic diseases. It should include cost containment mechanisms that do not compromise safety or access to needed drugs. It mus also have adequate financing. We recognize that a meaningful benefit requires a sizable commitment of Federal dollars, and that budget constraints are greater than last year. Nevertheless, the situation facing millions of older and disabled persons, who cannot afford the drugs they need, continues to worsen, and constitutes a healthcare and financial emergency that must be addressed.

We learned from last year's debate that more than $400 billion will ultimately be needed to design a meaningful benefit. Any Medicare reforms or provider give backs will require additional funding.

We understand the challenges in designing a meaningful Medicare drug benefit. We will provide assistance in every way we can to work with members on both sides of the aisle, because we all share the same goal, enactment of a meaningful and broadly supported Medicare prescription drug benefit this year.

I thank you again for inviting us to be here, and I'd be happy to answer any questions you might have.

Thank you, Mr. Chairman.

[The prepared statement of Erik D. Olsen follows:]

PREPARED STATEMENT OF ERIK D. OLSEN, AARP BOARD MEMBER

Mr. Chairman and members of the Subcommittee, my name is Erik Olsen. I am a member of AARP's Board of Directors and a Medicare beneficiary. On behalf of the organization and our 35 million members, I want to thank you for convening

this hearing and for including us in your discussions about how to design a much needed prescription drug benefit for Medicare beneficiaries.

Members of this Subcommittee have noted many times before that, given the prominence of drug therapies in the practice of medicine, if Medicare was designed today—rather than in 1965—not including a prescription drug benefit would be as absurd as not covering doctor visits or hospital stays. The focus of this hearing, therefore, is very important—rather than questioning whether to add prescription drug coverage to Medicare, the issue before us is how to do so. Enacting a meaningful and affordable prescription drug benefit for beneficiaries remains a priority for AARP, our members and their families. The addition of a prescription drug benefit is central to a 21st century Medicare program.

I am pleased to discuss AARP's recommendations and share with you some recent findings of what our members tell us they need in terms of Medicare prescription drug coverage. AARP members and their families are looking to you for leadership this year in making a prescription drug benefit in Medicare a reality.

Older and disabled Americans continue to face double-digit increases in drug spending and fewer options for coverage through employers or managed care. Thus, while modern medicine increasingly relies on drug therapies, the benefits of these prescription drugs elude more Medicare beneficiaries every day. The lack of drug coverage threatens access to needed medications for many older Americans.

Furthermore, the lack of a drug benefit in Medicare today poses "a perfect storm" scenario for the future:

- **Changing Demographics**—The retirement of the "baby boom" generation will nearly double the number of Medicare beneficiaries in the program. As people are living longer, they become more likely to develop chronic conditions treated with medications. Medicare must be prepared to handle the unique health care needs of a growing number of older Americans who reach not only age 65, but age 85, or even 100—and also a growing number of disabled individuals.
- **Increased Reliance on Drugs**—Prescription drug use increases not only with age but also with the prevalence of chronic and acute health problems. Nearly 90% of Medicare beneficiaries filled at least one prescription in 1999.
- **Higher Drug Spending**—Prescription drug costs among the Medicare population are rising rapidly. Total spending for prescription drugs is increasing at an annual rate of around 12 percent. By 2002, average annual out-of-pocket prescription drug spending by Medicare beneficiaries reached $860. This trend is projected to continue in the near future due to limits on drug coverage and other factors, including the continued introduction of new, high-priced drugs and potential increases in demand stemming from direct-to-consumer advertising.
- **Higher Prices**—While the majority of the increase in drug spending is due to greater utilization and shifting from older, lower cost drugs to newer, higher cost drugs, increasing drug prices are still an important component. Between 1993 and 2001, prices for all prescription drugs rose at more than triple the rate of inflation. Prices of brand name prescription drugs have been rising at three and a half times the rate of inflation.
- **Declining Coverage**—Most Medicare beneficiaries have some form of supplemental drug coverage, but access to these benefits is declining. Employer-based retiree health coverage is eroding. Managed care plans in Medicare have scaled back their drug benefits. The cost of private coverage is increasingly unaffordable. State programs provide only a limited safety net. About 40% of Medicare beneficiaries lack prescription drug coverage at some point in the year; most of these beneficiaries lack coverage for the entire year.
- **Impact on States, Private Sector, and Public Policies**—Increasing drug costs combined with the surging older population are already taking a toll on state budgets, private sector offerings and public policies. Medicaid spending on prescription drugs increased at an average annual rate of nearly 20% between 1998 and 2001. Medicare HMOs covering prescription drugs have reduced their benefit—more than 4 in 10 enrollees have a drug benefit cap of $750 or less. Until we achieve affordable and sustainable drug coverage in Medicare, pressures for other cost-reducing measures—re-importation, price controls, litigation—will only increase. Pressures will continue to squeeze not only public programs, but also businesses that will drop or restructure drug coverage.

Therefore, the need for a Medicare drug benefit for all beneficiaries will only continue to grow. Congress must act this year to provide Medicare beneficiaries with relief from the devastating costs of prescription drugs. Our country cannot afford to wait any longer.

What Older Americans Need in a Drug Benefit Design—Our members tell us that a Medicare prescription drug benefit should be:

- **Universal**—All Medicare beneficiaries need access to affordable, meaningful prescription drug coverage—whether they choose to stay in the traditional fee-for-service option or participate in managed care or any other coverage option.
- **Stable**—Medicare beneficiaries need stable and dependable drug coverage that they can rely on from year to year. Current prescription drug options are not reliable. For example, the share of large employers offering retiree health benefits is on the decline—24 percent of employers with 200 or more employees offered health coverage to their Medicare-age retirees in 2001 compared to 31 percent in 1997. In addition, beneficiaries who have drug coverage through Medicare HMOs cannot depend on having this coverage from year to year, as plans can change benefits on an annual basis or even terminate their participation in Medicare. For example, 50 percent of Medicare beneficiaries nationwide had access to a Medicare+Choice plan with prescription drug coverage in 2002 compared to 65 percent in 1999. Of the Medicare+Choice plans providing a drug benefit, 51 percent only covered generic drugs in 2002 compared to 18 percent in 2001.
- **Catastrophic Coverage**—Medicare beneficiaries need protection from extraordinary out-of-pocket costs.
- **Low Income Assistance**—A Medicare drug benefit should provide low-income beneficiaries with additional assistance.
- **Not Disruptive**—A Medicare drug benefit should not create more incentives for employers to drop current retiree coverage or disadvantage beneficiaries in the traditional Medicare program.

Over the course of the last two years, AARP has conducted research asking our members and the general public about the attractiveness of benefit design options. An attractive benefit is necessary in order to generate the high level of participation needed (i.e., the necessary risk pool) for a workable Medicare benefit. We have the learned the following thus far:

- Medicare beneficiaries are willing to pay their fair share for a meaningful prescription drug benefit, but the premium and coinsurance must be reasonable. We know, for instance, that beneficiaries would not be likely to enroll in a prescription drug plan with a premium of $50 a month. Our research suggests that a $35 a month premium is nearing the maximum amount that the public indicates it is willing to pay for *a stand alone* drug benefit, although willingness to pay any premium is highly dependent on the cost of the plan's other components.
- While the amount of the beneficiary premium drives the equation, our members also look at the program design features in combination with one another. This means it is difficult to assess a single component of a package. For example, some beneficiaries might look more favorably on a higher level of coinsurance if the premium was lower, or vice versa. In a poll conducted last year for AARP, of 885 individuals age 45 and over, only one-third of those 65 and over said they would be likely to participate in a prescription drug plan that included: a $35 monthly premium, 50% coinsurance, a $200 annual deductible, and a $4000 stop loss.
- Most Medicare beneficiaries are concerned about the unpredictability of health care costs and want to know what they will pay out-of-pocket. This makes real catastrophic stop-loss protection that limits out-of-pocket costs an important component of any package. Our members have indicated that a $6,000 catastrophic stop-loss is viewed as too high—since most believe they will never reach a cap at that level—and even a $4,000 cap is not viewed as providing adequate benefit protection.
- Public reaction to gaps in drug coverage ("donut holes") is highly emotional and deeply negative. Thus, any proposals containing such provisions, regardless of the cost of the other components, have always been very poorly rated in our research.
- Discount cards with discounts in the 10-25% range are viewed as not providing much assistance, particularly because this level of discount is available from other sources, such as current buying clubs or pharmacy chains. In addition, members question the price to which any discount will apply. Increasing the discount to a 30-35% range somewhat improves overall reaction.

Our findings thus far indicate—not only beneficiary preference—but also what is necessary to create a benefit that is attractive enough to yield a broad risk pool and to build a strong and viable program. We will continue to seek the views of AARP members and future members on specific design packages and we would be happy to work with this Committee as proposals are developed.

ADDITIONAL POLICY CONSIDERATIONS IN DESIGNING A DRUG BENEFIT

Adequate Financing—The first step in designing a Medicare drug benefit will be to ensure that enough money is available in the budget to accomplish this goal. We recognize that to design the kind of prescription drug coverage that beneficiaries will find meaningful requires a sizeable commitment of federal dollars. We also recognize that budget constraints are greater than last year. But while the budget situation changes from year to year, the situation facing millions of older and disabled persons who cannot afford the drugs they need continues to worsen, and constitutes a health care and financial emergency that must be addressed.

The House and Senate budget resolutions now in conference allocate $400 billion over ten years for prescription drugs, program reforms, and provider givebacks. As we all learned from last year's debate, more than $400 billion will ultimately be needed to design a Medicare prescription drug benefit that will attract enough beneficiaries. AARP has urged the budget conferees to allocate the full $400 billion for a prescription drug benefit and we further believe that Congress will need to revisit the budget amount in order to facilitate the enactment of a workable benefit design. Any Medicare reforms or provider givebacks will require additional funding.

Cost Containment—We recognize that strong and effective cost containment measures are a necessary part of a Medicare prescription drug benefit. In order for a drug benefit to be sustainable over the long run, mechanisms must be in place to control the rising costs of prescription drugs. AARP actively supports solid cost containment methods as long as patient safety and well-being is not compromised and access to prescription drugs is not impeded. We also support the responsible promotion of generic drugs as one effective cost containment tool.

Chronic Care—Improving how chronic care services are provided in Medicare is another major challenge facing the Medicare program of the 21 century. The inclusion of a prescription drug benefit in Medicare would greatly advance efforts to address this challenge, because high quality treatment of many chronic conditions is inextricably linked to prescription drug therapy. Millions of beneficiaries who suffer from chronic conditions must have access to such state-of-the-art drug therapies if they are to receive high quality chronic care. Further, in order for Medicare to ensure high quality care and quality improvement, it must have access to prescription drug claims and utilization data. Having such data would permit providers and QIOs to link information on prescription drug use with hospital and claims from other care settings, thereby facilitating disease management and similar strategies that help to address the needs of individuals with chronic conditions. In the long run, such efforts should not only help to improve care, but may also reduce unnecessary hospitalizations or nursing home stays.

Quality and Safety—A Medicare prescription drug benefit should also be designed and administered in a way to promote higher quality and safe use of pharmaceuticals. This can be accomplished, for example, through discount cards that track pharmaceutical purchases and are connected to electronic systems that flag potential problems for the physician or pharmacist.

Structural Reforms—Some policy makers have urged that prescription drug coverage not be undertaken without fundamental changes in Medicare. AARP believes that there is room for some improvements in Medicare. The addition of a prescription drug benefit is one example. Better delivery of care to chronically ill beneficiaries is another necessary improvement. Any changes to Medicare, however, need to improve the program and its ability to provide affordable health care to older and disabled Americans. We would not support reforms that put the traditional fee-for-service program, upon which millions of beneficiaries rely, at a disadvantage.

AARP believes we should strengthen Medicare for the decades ahead. We must acknowledge the fundamental importance of this program to older Americans who have come to rely upon and value the health coverage it provides. Medicare is a great success story in a health care system where tens of millions of Americans remain uninsured. We advocate sensible improvements to strengthen Medicare, as long as they include prescription drug coverage and ensure that the program remains the solid rock of health care upon which more than 40 million Americans rely.

Conclusion—Our members believe that Congress should work to achieve the goal of an affordable Medicare drug benefit this year. We understand the challenges in designing a proposal for a responsible Medicare drug benefit that can take us through the 21st century. We pledge that we will provide assistance in every way we can to work with Members on both sides of the aisle to adopt a meaningful and broadly supported Medicare prescription drug benefit.

Mr. BILIRAKIS. Thank you, very much, Mr. Olsen.

Well, in 1988, and we'd like to more often than not forget this, Congress passed a Medicare Catastrophic Coverage Act, which among other things added, as you may recall, catastrophic drug benefit to the traditional Medicare program. The legislation was repealed months after it was enacted in 1989.

It would have provided a drug benefit with a $600 deductible and 50 percent co-insurance at drug purchases, et cetera, et cetera. There are more parts to it.

Doctor Crippen, this certainly was not your responsibility at the time, I really don't know off hand what you were doing back in 1988-1989.

Mr. CRIPPEN. Actually, I was working for President Reagan on this issue at the time.

Mr. BILIRAKIS. Oh, you did. Well, in any case, the CBO cost estimate of the plan at the time of enactment was $5.7 billion over 3 years, and we know that less than a year later these estimates doubled to $11.8 billion. What was the reason for that, very briefly.

Mr. CRIPPEN. I'll tell you that I don't know the exact reason for that doubling. I will tell you that having been working in the administration at that point we thought at that time the CBO estimates were too low. In fact, the HHS actuaries were, I think, as I recall, in the neighborhood of $12 to $15 billion. So, I think the CBO estimate was just, frankly, too low. I don't know exactly why.

Mr. BILIRAKIS. What did they do during that particular period of time to, basically, double the estimates? Did they go back into it?

Mr. CRIPPEN. They reexamined their techniques. I'd like to think we talked them into reality from the other end of the street, but I'm not sure. Doctor Reichauer, as I recall, was the Director then, and I have not discussed with him what exactly changed in that period, but it was not a change of facts so much as it was a change of projection of the future.

Mr. BILIRAKIS. Mr. Olsen, you heard Mr. Herman, and I've heard from many beneficiaries who, basically, have said, look, give us a plan, make available to us a plan that's similar to the plan that you have as a Federal employee. And, Mr. Herman, basically, thinks that we ought to have a drug benefit modeled after the Federal Employee plan.

Well, tell me, what would be wrong with that?

Mr. OLSEN. First of all, I want to emphasize that the current Medicare program, including Medicare+Choice, have rather substantial private sector components involved in them at the current time.

Mr. BILIRAKIS. All right.

Mr. OLSEN. So, there is——

Mr. BILIRAKIS. And, that's bad.

Mr. OLSEN. [continuing] "private sector" no, I'm saying that is true, and Medicare is a very popular program, as I think you all understand.

One of the concerns that we would have is there is a different population with different needs, and more chronic illnesses, and that type of thing. Also, there are many seniors who are on fixed incomes which do not increase year to year, and, therefore, there's probably a greater concern relative to the stability of the program

from year to year, so that the rates go up but my fixed income does not go up.

Mr. BILIRAKIS. Of course, Part B keeps going up.

Mr. OLSEN. I understand that.

Also, it's very critical for seniors to know, as far as the stability, to know that they have a defined benefit, guaranteed by the Congress in the law, that they can receive so that they don't have to worry, like current participants, some of my friends in Medicare+Choice, to wonder if their plan will include prescription drugs this coming year or not. So, the stability, or in some cases even if they are going to be in business, if they go out of business, so it's very important that the benefit be defined and there not be a year-to-year concern by the beneficiaries and they get yanked back and forth.

Also, there does seem to be a problem in the geographical differences, and not, for instance, Medicare right now not all areas are covered by private, by Medicare+Choice. That would have to be.

So, those are some of the elements we would be concerned about as we build.

Mr. BILIRAKIS. Of course, if this were to take place, obviously, you'd have to solve that particular problem, make sure that the access is virtually equal all over the country.

In your opinion, do you feel that the Medicare, that today's Medicare beneficiaries versus, let's say, 20 years from now the Medicare beneficiaries, would have a bigger problem in terms of making the choices, arriving at the choices?

Mr. OLSEN. You raise an interesting point and probably not. I can't really look ahead 20 years, but in one way I can look back 20 years. I had the assignment, if I might say, of when they passed in 1997 the balanced budget with all the new choices, the different alphabet choices, of explaining that to one of the senior areas of Sun City in Arizona. And so, I got up and started explaining. I was at least 20 years junior of anyone in that room probably, lots of widows, and I'm sure you've done this. I was so proud of myself, it was hot off the press, I was explaining all these new alphabet choices, and I got about half way through and I saw everybody out there in the audience was aghast. And so, I finally figured out that what I said to them, but, wait a minute, I says, you don't have to change out of your current plan or change your doctor, and you could almost see the audience——

Mr. BILIRAKIS. Sigh of relief.

Mr. OLSEN. [continuing] sit back in their chair.

So, I relate back to 20 years ago. They were worried about choice of doctor, and so have we changed in 20 years, to say myself, probably. Will we change in 20 more years? I suppose.

Mr. BILIRAKIS. People will be going on to Medicare who had been parts of managed care plans through their employer for the most part, and somewhat more familiar than they were 20 years ago, or even today, would you say?

Mr. OLSEN. I would say that's true, but I think we still ought to probably recognize very much that as when people get to the age probably of the people I was talking to at that time, they are not, you know, you really have to have it as adaptable to change.

Mr. BILIRAKIS. Yes, I've experienced that, too, in my congressional district.

Thank you, Mr. Olsen.

I'm sorry I took a little more time.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. Crippen, you made a very cogent case against the President's tax cuts. I very much appreciate that. I've noticed, if I could enter it into the record, budget and policy priorities points out that the tax cut will consume over the next 75 years between 2.3 and 2.7 percent of GDP, the Medicare and Social Security deficits will consume about half that. The tax cuts will be somewhere between $12 and $14 trillion over 75 years. The deficits of Social Security and Medicare funds will be about slightly under $10 trillion, so I think the gloom and doom about Medicare and Social Security are a bit overstated, and I think our country absolutely can afford this program.

Mr. Chairman, I'd like to enter this in the record, if I could.

Mr. BILIRAKIS. Without objection.

Mr. BROWN. I would like to ask Mr. Vladek a question. First of all, thank you for your emphasis on simplicity. I sat through this mark-up last summer in this subcommittee and in the full committee on the prescription drug bill, and then the Republican plan was so confusing with donuts, and co-pays and deductibles, and I think seniors, the importance of simplicity cannot be overstated.

Mr. Vladek, as you know, premiums in private plans have increased rapidly in the past few years. The FEHB has increased 9 percent per year for the last 5 years, in fact, it increased 13 percent last year, employee share of Blue Cross, Blue Shield standard option has gone up 15 percent. CALPERS, the California State Employees system, similar to FEHB saw premiums increase 25 percent last year.

And, if you would, when you look at people wanting to go in and privatize this system, and push a lot of managed care into the full panoply of choices that they misleadingly talk about with private systems, what happens to the whole issue of defined benefit versus defined contribution with seniors having to pick up more of the cost? Is that as big a problem as some might suggest?

Mr. VLADEK. I would have a great deal of concern that any effort that turned all of the Medicare program into a fixed contribution, rather than a purchasing of a defined set of benefits, would, in fact, over time lead irresistibly in years of tight budgets, in years of other demands on the Federal Treasury and so on and so forth, of a shift of an increasing share of the costs of the program to Medicare beneficiaries on average. But, I'm even more concerned, and particularly when we talk about the particular issue of prescription drugs, with the ability to manipulate formularies, with the ability to manipulate coverage patterns, or patterns of co-insurance and deductibles, to shift relatively more costs to the sicker beneficiaries, rather than less sick beneficiaries.

In insurance for prescription drugs, the penalties to the insured from adverse risk selection are potentially so great that unless you standardize the nature of the benefit, in which case you wonder why you need the private plans at all, the necessity to prevent

gaming of that in order to maximize risk selection on the part of the insurers seems to me to be very substantial, and I don't know how to do that, from the point of view of administering the Medicare program.

So, I would be concerned, in general, about efforts to move Medicare from a defined benefit to a defined contribution program. I'd be particularly concerned in the context of a discussion of the drug benefit about the creativity of private insurers and private PPMs to target high risk, high cost beneficiaries and design their plans to minimize the benefits they'll have to provide to them.

Mr. BROWN. Do you see evolving a two-tier kind of Medicare, where the sickest have the highest costs, and those costs are often shifted to the beneficiary?

Mr. VLADEK. That's where I would be concerned about, if we're not very careful. I think we devoted a lot of time on both sides of the aisle in constructing the Balanced Budget Act, and constructing Medicare+Choice to minimize that in Medicare+Choice. That may be why Medicare+Choice hasn't enrolled more people than it has, but I would just, again, as we design a prescription drug benefit, I think given the nature of the use of prescription drugs, and of the insurance for prescription drugs, that's a particularly significant risk, and we need to be very careful about it.

Mr. BILIRAKIS. Do you see, Mr. Vladek, an effort on the part of the majority party to shift possibly the costs to the low-income people, as Mr. Brown put it?

Mr. VLADEK. I have expressed concern, Mr. Chairman, in the past on the part of advocates from both the majority party and the minority party, for so-called support or other approaches to the Medicare program, which I fear over time would, in fact, shift more of the costs to beneficiaries.

Mr. BILIRAKIS. Thank you.

Mr. Whitfield, for 8 minutes.

Mr. WHITFIELD. Thank you, Mr. Chairman.

I want to thank all of you for attending today. We genuinely appreciate your comments, and as we prepare to pass another prescription drug benefit on the House side, of course, we've already done it twice before, and the Senate still has not acted, but as we prepare to do that again, I think Mr. Crippen touched on something that all of us are thinking a little bit about, and that is Medicaid is in dire financial straits right now, almost every State is running a deficit. We know that Medicare is becoming more and more expensive each year, and the Part B, paid by the government, is increasing, and the percentage paid by the beneficiaries is decreasing percentage-wise.

In addition to that, our Social Security program, by the year 2012, there's going to be more money going out than coming in through the payroll tax. And, we set aside $400 billion over 10 years for this prescription drug benefit, and I think everyone recognizes that it's probably going to be much greater than that, and it will be an entitlement so it will have to be paid.

And, as we think about that, I think it's imperative that we also consider those uninsured people out there in our society, many of whom do not have any health insurance at all. Their employer doesn't provide it for them, they can't afford to buy it themselves

and provide healthcare for their families, because they are just a little bit over the line so they are not eligible for Medicaid, they are not old enough to be on Medicare. And so, that's a big segment out there that right now they have nothing.

So, in trying to balance all of these, I would like to ask Mr. Olsen, it's my understanding that your organization's position has been that this benefit would be available to everyone, every senior citizen, and I know the means testing is not a popular word, but considering the financial situation of our country today, and all those things that I mentioned, why would your organization be opposed, for example, if somebody like Warren Buffet paying for his health, his prescription drugs?

Mr. OLSEN. I can't speak for Warren Buffett. However, first of all, the first part of your question had to do with the general problem of the uninsured and the critical problem of the uninsured between and before they get to Medicare, which probably just highlights the importance of Medicare in another way.

I can assure you that it's also one of AARP's priorities, it's not the subject of this hearing this morning, but that is another one of our top priorities, is to work in that area.

But, let me talk about, you mentioned means testing and Warren Buffett, or Bill Gates. I would like to be sure we define the terms, means testing and income relation. Means testing is putting a dollar amount on income, or net assets, or something, and beyond that point you do not get whatever it is.

Mr. WHITFIELD. Well, let me just give you a hypothetical. Considering the situation today, and we're just trying to get this program going, which is what we want to do, just from a philosophical standpoint, are you and your organization opposed, for example, to saying any senior whose income is above $80,000 a year, let's say, they would have to pay for everything, for prescription drugs.

Mr. OLSEN. Okay. Our position is, we do oppose what I defend as means testing, but we are willing to discuss, and think it should be part of the discussion as we build this structure, something called income relation. And, there are administrative problems with doing that, but that would imply that those with higher incomes, and I don't have any idea what that number is, but higher incomes, would, perhaps, pay a higher premium for some coverage. So, we are open for that discussion.

But, we are opposed to means testing, which cuts off a certain element, because it seems to me that somewhat violates the social contract that those who paid in will receive the benefits. So, I hope that clarifies where we are on that issue.

Mr. WHITFIELD. And, I appreciate that, because I think that's a reasonable step, that there would be some relationship to salary on what you pay.

Mr. BARTON. Would the gentleman yield?

Mr. WHITFIELD. Yes, sir.

Mr. BARTON. Define income relation. I mean, I've never heard that term.

Mr. OLSEN. There's a subtle distinction, and a lot of people use the word means test, but means test is a more limited. That's, at some point, you just don't get the benefit, you make too much, or you have too many assets. That we are opposed to.

Income relating is probably your income on the 1040 or whatever, at a certain level you would pay more, but you would still receive the benefits.

Mr. BARTON. It's a sliding scale.

Mr. OLSEN. It would be more that, yes. And, I'm glad that question was asked, because I think there is not total understanding between the two, and we think that second part should be open for discussion as we build on the framework of this program.

Mr. BILIRAKIS. Would the gentleman yield, so, basically, you don't like the term means testing, because you feel that every Medicare beneficiary who has paid into the system ought to be able to receive the benefits. But, what you are saying, that they would receive the same benefits, but in terms of their contribution would be related to their income.

Mr. OLSEN. I think that can be a part, you know, not total—that can be part of the discussion, yes.

Mr. BILIRAKIS. Good, thank you.

Mr. WHITFIELD. I want to thank you all for asking questions on my time.

I would like to ask, last year we passed a plan that, basically, said that there would be a $250 deductible, the first $1,000 the beneficiary paid 20 percent of that, the second $1,000 the beneficiary paid 50 percent of that, and then between there and $3,700 the beneficiary pay all of it, and then after $3,700 the government would pay because there would be a cap on our out-of-pocket expenses.

And, Mr. Vladek and Mr. Olsen, I would like to ask you, what is about that particular plan that you have problems with?

Mr. VLADEK. Well, Mr. Whitfield, I can't do all the arithmetic as I'm sitting here, but looking at those numbers and looking at drug expenses for Medicare beneficiaries, I think any arrangement of that sort, wherever you put the exact points in coverage, means that for many beneficiaries the net value of the benefit, over and above what they are paying in a premium, gets to be very, very small. And, some of those are people with very significant needs.

The extent to which a plan like that one effectively meets the objective of providing financial protection and improved access for beneficiaries varies then enormously, depending, to some extent, on happenstance, or whether one's principal problem is a cardiac problem for which there happened to be generic drugs, or a kidney problem for which all the drugs are brand name and, therefore, more expensive. And, it would produce, I think, very significant inequities among similarly situated Medicare beneficiaries, which I think is exactly the sort of thing we don't want to do in designing a benefit.

I understand the need to get control of expenditures and make the numbers work out right, but I think arrangements of that sort, given patterns of drug use among Medicare beneficiaries, create a real risk of significant inequities between similarly situated beneficiaries.

Mr. OLSEN. I'm not an actuary, and I defer to that, but I would refer back to my experience at Sun City trying to explain it to someone. Be as simple as possible.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Mr. Pallone for 5 minutes.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to ask Mr. Vladek and Mr. Olsen, in my opening statement I mentioned how in New Jersey we have about 80,000 seniors who have lost their health coverage after the private HMOs, basically, dropped them. I know that the administration and the Republicans may not say that they are necessarily privatizing or relying strictly on HMOs to provide a prescription drug benefit, but that's the way I see it, and I'm sort of operating on that assumption in answering my—asking these questions.

I don't understand how, you know, all I hear from my seniors is, we joined an HMO and they dropped us, or we joined an HMO and they've cut back on the benefits, or we've joined an HMO and, you know, the co-pay is going up, or, you know, the premium costs are going up and I can't afford it, in order to keep, you know, their prescription drug benefit. And, how in the world the administration or the Republicans figure they are going to come up with a new program to cover prescription drugs when the existing program is, essentially, a failure in providing the very benefit that they are now saying they are going to provide with it. So, to me, it's just amazing.

I mean, if you look at this chart, this shows how, basically, premiums under various programs, you know, private programs if you will, have gone up on the average per year, I guess, for the last 10 years. If you compare that to Medicare, which has gone up 6.7 percent per year, the premium cost, over the 10-year period on average, I mean the bottom line is that premiums are going up in these private plans, it's costing more and more.

So, when the Democrats say, look, the best thing to do is provide a guaranteed benefit under Medicare, like Part B, for prescription drugs, and then the Republicans say, no, that's not a good thing to do, we're going to rely on the private sector, we have nothing out there to indicate that this is going to happen successfully, only a series of failures over the last five or how many years that, you know, the HMO option has been out there.

So, I guess I would just ask, I guess I'll start with Mr. Vladek, and then Mr. Olsen, how do you build a program of this magnitude on a series of failures, or am I missing something?

Go ahead, Bruce, if you will, and then I'll ask Mr. Olsen.

Mr. VLADEK. Mr. Pallone, just a quick thing, I think these charts are the most recent year's increase. I think, in fact, private health insurance premiums have grown more quickly than Medicare costs over the last decade, but CALPERS hasn't averaged 25 percent a year, it's just this past couple years have been very bad.

But, I think it's important to emphasize that there are still 5 million plus Medicare beneficiaries enrolled in Medicare+Choice plans, and many of them are very happily so, and some of them are getting relatively good benefits. The problem is, I believe, if you look at the history of private plans and Medicare, that what you can't do at the same time is provide additional benefits, attract and keep private health plans in the system, and save money. The three are mutually incompatible. It is almost impossible for a private managed care plan, as the heads of some of the best private managed care plans in northern California or in the Twin Cities will tell you,

to provide high-quality services at a cost equivalent to Medicare fee-for-service costs in their communities. They have marketing costs, and enrollment costs, and administrative costs, let alone the issues of profitability that the Medicare fee-for-service program doesn't have, and even if they are more efficient in utilization they are not that much more efficient in utilization.

So, the Balanced Budget Act, when we were overpaying the HMOs very substantially in Medicare, they wanted to come in the program and they were happy to provide additional benefits in order to get enrollees, and it was still a very good experience. When we brought the price differential between what we were paying the private plans and what we were paying in fee-for-service down in the Balanced Budget Act, a growing proportion of the private plans couldn't compete under those circumstances.

So, I believe, and again, there are these problems of inter-regional differences, which are horrendous and I believe insoluble, and which, given the organization of the House of Representatives in the U.S. Congress will present enormous problems no matter what you do, because one district will be different from another district.

So, you can have more participation of private plans, you can use private plans to get more benefits, if you are prepared to pay a substantial premium for it. But, if you are trying to minimize expenditures then a centrally administered, government administered plan, is going to be more cost effective.

Mr. PALLONE. I don't know if we have time for Mr. Olsen, go ahead.

Mr. OLSEN. Again, I want to emphasize that all elements of the current Medicare system have private elements in it, including all the proposed prescription drug.

I want to emphasize again, we are looking for stability from year to year, and that I don't see how it can be accomplished other than have a defined benefit within the plan. And, what we are really interested is that whatever private plans the Medicare beneficiary has a choice for does not undercut the current Medicare program or disadvantage any of the current Medicare beneficiaries, so that there's an equal playing field and an equal choice. That's our position.

Mr. PALLONE. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Ms. Wilson for 5 minutes.

Ms. WILSON. Thank you, Mr. Chairman.

Doctor Feldman, I noticed in your testimony that you talk about and give some examples of some of the partnerships and things that have worked with the private sector. I wonder if you could expand a little on that and see whether, and share with us more than just the example, but what you think there is in behavior that we can learn from here, and how we might incorporate some of those principles into a Medicare prescription drug benefit.

Mr. FELDMAN. That's a big question.

Ms. WILSON. Yes, it is.

Mr. FELDMAN. Let's just start off with the formularies that most of the private drug management firms use. Those have the potential to reduce costs by somewhere between 5 to 9 percent, according to one estimate by Merck Medco, according to another one by Ex-

press Scripts they might reduce the costs by 6 percent. They do that by redirecting the incentives of providers and consumers to use the drugs that are on the formulary and to substitute for generic drugs if those are available.

The episode that I mentioned in Blue Cross and Blue Shield showed that it's also possible to redirect physician prescribing patterns without using financial incentives, and that was done by educating physicians to use drugs that our Blue Cross plan had deemed to be the most cost effective. So, those are two examples that I would give you, the use of financial incentives in a formulary, and educational programs that private health plans can run with their providers who redirect behavior.

Ms. WILSON. Thank you.

I had question, and, perhaps, Doctor Feldman, you are also the one to answer it. Why do you think that the Medicare+Choice competitive demonstration model was never implemented?

Mr. FELDMAN. Quite simply, I believe it was opposition from the interests who opposed it on the grounds, essentially, that it would reduce the prices that were being paid, the premiums that were being paid in the demonstration areas.

Ms. WILSON. Thank you.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks the gentlelady.

Ms. Capps, for 8 minutes.

Ms. CAPPS. Thank you to each of you panelists, since I didn't do my opening remarks I'll take a minute to tell you, and also to thank our subcommittee chair for holding this hearing.

Across this country, no matter what is going on in the world, a sizable percentage of our population has this topic as its highest priority for us to do something about, and they've been waiting rather impatiently over the years.

As you did give in your testimony, and as I've listened to some of my colleagues, I've been mindful of the reasons Medicare was enacted almost four decades ago. Wasn't it because the private insurers were not able to cover this population, higher-risk population, in an affordable way? And so, Medicare was created, and I'm going to ask you pointedly in a minute, Mr. Olsen, but since you represent probably more seniors here at the table than anyone, I think I'm a member of your organization as well, what seniors want is stability and a defined benefit that they can count on over time. Medicare has come to mean that for more than one generation of seniors by now.

So, here we are, at the cusp of a—well, many of us feel we are in a crisis, because of the cost of prescription medication, the way seniors are staying healthy and alive is not the same as it was in the '60's, yet we have this burst of technology that gives us possibilities for living independently, being healthy and productive much longer, many more decades than before, and that's the challenge of paying for the means whereby this generation now, and particularly the baby boom one coming behind it, is going to be able to have at its disposal the means to be healthy and to continue to be a vibrant part of a community.

So, we have, in the last 5 years or more, Medicare+Choice as an option, and it's now being proposed that it become a central part

of Medicare prescription drug coverage. However, it's interesting, and this has been talked about a bit, it's interesting that Medicare+Choice enrollment since 2000, this is from the Kaiser Family Foundation, has declined by 27 percent. Now, it is no longer 4.6 million beneficiaries, but it is now 11 percent of the Medicare population, and that's what I wish to discuss with you.

Let me ask you, am I correct in listening to you, Mr. Olsen, that when you speak to the seniors in Sun City they really are, they are interested in choice, but mostly of their physician, that Medicare fee-for-service has provided them over the years, and with respect to their prescription medications are interested in stability, that the price that they are paying this year, they are already paying way more than they can afford on their fixed income, these are not salaries, these are fixed income seniors, that as time goes on they want that price to stay where it is.

Mr. OLSEN. I'm not sure of your question, but I have a couple of comments on your's.

You mentioned about that we are having this discussion today, and people are still interested even while we are at war. I had a presentation in Ohio on about September 14th of 2000, right after 9/11, and it was on prescription drugs for Medicare. We thought no one would show up, went ahead with the presentation. The place was packed, and I think that while everybody was still in mourning over this.

So, and you know you say is this still needed, I talked to my own Medicare doctor about a week ago, I had an appointment, I asked him about, you said about the middle income and fixed income, I says, how does this work in your practice? He says, "I have a lot of people, middle-income people, that are having big problems." Especially, he noticed the diabetics, they need some rather, a series of expensive drugs, $300, $400, $500 a month, they do not have that much money.

I said, "What do you do?" He says, "I give them samples, and when I run out of the samples I give them a different drug." Then what he said, "If I run out of that sample, they are out of luck."

Ms. CAPPS. And, Mr. Olsen, I want to stress, this physician is talking about his, not his low-income patient.

Mr. OLSEN. No, not his low income, he specifically said his average working man, middle income, and this is in Carson City, Nevada, working class city.

Ms. CAPPS. So, a program that is specifically targeting low-income seniors is not really going to adequately address the challenge that we face in terms of talking about prescription drug benefits.

Mr. OLSEN. I don't want to, you know, in any way say that there shouldn't be additional assistance for low-income people, but probably it should be outside of the Medicare program, because the program goes way, way beyond that.

You know, two thirds of the people over age 65 rely on Social Security for at least half their income.

Ms. CAPPS. That's correct.

Mr. OLSEN. I don't think that falls in the wealthy category.

Ms. CAPPS. I agree.

I want to just make one comment about something that, Mr. Herman, you said, in terms of holding up FEHBP as a model, and believe me for a Federal employee it is a wonderful healthcare benefit, I wish everyone in the country could have it. However, it's not the same risk pool as Medicare, I hope you agree with that, and I just want to mention the fluctuation within the plans, and the terminating plan service area withdrawals, since 1998 that year 66 plans terminated, 1999 42, 2000 32, maybe it's stabling down, but there certainly is not total stability within the plans even offered by FEHBP.

But, I really want to concentrate on a topic, Mr. Vladek, that I want to address to you, and this has to do with a person who came to me in my office hours, sidewalk office hours, in front of a grocery store in Santa Maria, a rural agriculture community, because we are talking about a rural population, she was 55 in a wheelchair, but she wasn't—she was coming on behalf of her parents pushing 90.

This is not unusual nowadays, and they were enrolled in a Medicare+Choice plan that had subsequently left, and she was struggling. She had her own health needs and her own needs as a Medicare recipient herself. Here's two generations worth, how are we going to address, and you touched on some regional issues, but I really want to deal with this, it's going to be really hard for these constituents of mine in the rural part of my district to buy into a plan that's being proposed by the administration where all of the benefits, or almost all the benefits, and for prescription medications, are a part of an HMO that they have had very, very poor success with?

Mr. VLADEK. Well, I think that if you are serious about choice, that there has to be the full choice, that's the heart of FEHBP. I don't know what the numbers are now, the last time I looked 70 or 75 percent were in one of the two Blue Cross standard option or plus option, which looks a lot like the Medicare program to me except that Blue Cross takes a few percent off the top that doesn't occur in the Medicare program.

But, I think the real issue is that people should no more be required to enroll in a private plan that they don't like than the fact that they should not have the option to enroll in a private plan if it's there and if they like that better than the traditional fee-for-service Medicare. It's about choice.

Mr. BILIRAKIS. The gentlelady's time has expired. You've had 8 minutes, Lois.

Ms. CAPPS. Okay, thank you.

Mr. BILIRAKIS. Doctor Norwood, 8 minutes.

Mr. NORWOOD. Thank you very much, Mr. Chairman, and I'd like to thank the panelists, one and all, for being here, and particularly Mr. Herman who was here up from Georgia, we are glad to see you all today.

Mr. Crippen, I want to ask you a question in just a minute, and I'm going to tell it to you now and want you to think about it. I'd like you to summarize your statement, the important part of your statement, in about three or four sentences in just a second. I'll come back to you.

Mr. Olsen, I'm curious, the AARP membership, what percent of your membership, for example, is 60 years and older?

Mr. OLSEN. I don't have that number, we'll get it to you, but to give you a little perspective, about half of our membership, and it just varies a half, is still working. So, I don't know the exact number at 60, but we'll get that to you.

Mr. NORWOOD. I'm curious.

Mr. OLSEN. But, that will probably give you a—that's probably not so far off from the number who are working, let's say, so it's about half are still working and half retired.

Mr. NORWOOD. It is of interest to me which side you'd take on this. One side——

Mr. OLSEN. I'll get that information for you.

Mr. NORWOOD. [continuing] wants affordable, I think is the word you used, and meaningful benefits, and the other side is worried about making their house payments or sending their children to school, and that's got to be quite a conflict for you, if half of them really aren't on Medicare and half are.

What, by the way, does affordable mean? You pointed out that the AARP wanted an affordable benefit. Mr. Herman, I'm going to ask you the same question, what does affordable mean?

Mr. OLSEN. Well, you can look at it from two directions, I suppose. We talk, we've done some research on the premium I mentioned in my testimony, and I gave the number $35 as premium, but, you know, it gets better for them at $25, so that's one level of affordability.

Mr. NORWOOD. So, if we had a premium of $35 you would consider that affordable?

Mr. OLSEN. Well, you see, everybody has got to make the kitchen table test on this, and the research we get is 50 is way too much, 25 is a lot better, but there's some number in this. That's one thing.

Mr. NORWOOD. No matter what we make it somebody is not going to like it.

Mr. OLSEN. Of course, yes.

Mr. NORWOOD. We were trying to do exactly like you wanted it, I was hoping you'd tell us what affordable would make all of your members happy.

Mr. OLSEN. Oh, all of them? Actually, of course, in any program premium is just one element of it, and there will be co-payments, there will, perhaps, be deductibles. I hope there isn't a donut hole, there will be catastrophic levels, whatever there might be, so all that is interchangeable.

Mr. NORWOOD. Well, I agree with you, all of us want to give everybody everything they want. We just don't want to back up from anything.

Mr. OLSEN. We also understand——

Mr. NORWOOD. Mr. Herman, tell me what you think affordable means?

Mr. HERMAN. A couple things. Firstly, we don't think a program that pays 53 percent of medical costs in 2002 as reported by CMS is affordable, it's pretty darn expensive.

We understand that to someone poor full coverage is affordable. They can't pay anything more. We also understand from a lot of

our membership that they've worked five decades, they've saved something, they'd like to pass a little of it on. A cap on prescription costs is affordable, they can pay something, they've paid all their lives.

But, right now there is no cap. I have a father, I had a father who died a year ago of Alzheimer's. Let me tell you, it wasn't affordable. Well, so everybody is talking about affordable, they mean what is affordable to the receiver of the benefit, not necessarily what is affordable to the payer of the benefit, meaning the taxpayer. I'm just trying to make sure we are all focusing on just one part of this.

The 53 percent that Medicare pays, that sounds to me like somebody is managing the costs for it to be just 53 percent.

Mr. HERMAN. There are a number of things that are happening. We spoke with a doctor last week who is dropping his Medicare practice, he's not going to do it anymore. And, it's his words, not our's, but he says that, you know, I'm being made a partner with the government, when all I really want to be is a doctor and take care of people. I can't pay my bills. I'm not getting reimbursed very well, and every time I turn around what is reimbursed to me has been reduced, and I've got a family to take care of and I'm moving on now.

Mr. NORWOOD. So, CMS is managing cost and care exactly or much like the private industry, referred to earlier by Mr. Brown, is managing cost in care.

Mr. HERMAN. Yes.

Mr. NORWOOD. You can't really sit here and say I hate managed care, because when you say I hate managed care you've got to mean you hate managed care CMS just as much as you hate managed care in the private industry. By the way, I fall in that category.

Mr. Crippen, your turn. Summarize quickly for me what you said.

Mr. CRIPPEN. I thought I did that before.

Mr. NORWOOD. No.

Mr. CRIPPEN. There are only two larger points. One is, many of the elderly today are getting—have access to drugs, not necessarily in a way that's the best way. Many of them may not be able to afford what they are paying out of pocket, but most of the elderly, 75 percent are insured some way or another.

Mr. NORWOOD. Their outcome in 2030 is where I'm trying to get you to go.

Mr. CRIPPEN. Right.

Mr. NORWOOD. If we do nothing, what do you anticipate our problems will be, at the taxpayer level, the Federal Government level, in 2030?

Mr. CRIPPEN. Even without a drug benefit, Mr. Norwood, it's likely we would need a payroll tax equivalent of about 35 percent of payroll on workers at that time, in order to——

Mr. NORWOOD. What if we didn't do that?

Mr. CRIPPEN. What if we didn't?

Mr. NORWOOD. Yes. What if we didn't have a payroll tax, what is the cost to our annual budget?

Mr. CRIPPEN. Well, it's, roughly, a trillion dollars a year in current dollars.

Mr. NORWOOD. What percentage would our annual budget go?

Mr. CRIPPEN. To about 25 to 30 percent.

Mr. NORWOOD. I've heard 35.

Now, does that include, are you calculating that number based on if there are any tax reductions or if there are not, or is that based on just as we are today?

Mr. CRIPPEN. In this point of view, the tax reductions are relevant, and the point is, how much are our obligations to the elderly versus how big is the economy that our kids are going to have to pay us with.

Mr. NORWOOD. Is that sustainable?

Mr. CRIPPEN. I suspect it's not in this country. We've only collected, since World War II, an average of 18 percent of GDP in Federal taxes, and it's actually been relatively constant. It goes up and down, obviously, but 18 percent has been the average since World War II.

We are talking about going to 28 percent, for example, in order to sustain these programs. Now, you know better than I what's politically acceptable and sustainable, but we will look very much like some of our European counterparts in terms of Federal tax policy if we just increase taxes to cover these costs.

Mr. NORWOOD. Not necessarily that statement, but I'm interested to know from the rest of the panelists, do they agree with Mr. Crippen on this. If we do nothing, if we continue to let the program go like it is, not add a drug program, just let things go like they are, in 25 or 27 years, if we are at the point 35 cents out of every dollar goes to these programs, do you all think he's wrong? Is he overstating that?

Mr. BILIRAKIS. You don't have the time for every member of the panel to respond to that.

Mr. NORWOOD. How about a yes or no?

Mr. BILIRAKIS. Yes or no, yes.

Mr. VLADEK. He's not wrong.

Mr. BILIRAKIS. Mr. Vladek can't hold himself to a yes or no.

Mr. VLADEK. He's not right because we can't predict 25 years.

Mr. OLSEN. I'm not an economist, but I thought the seniors and doctors were part of the economy, too.

Mr. BILIRAKIS. Mr. Green to inquire.

Mr. GREEN. Thank you, Mr. Chairman.

Let me ask this, although, Mr. Feldman, since you mentioned it in your testimony, that administrative costs, and marketing costs, and payments to investors, would not outweigh the private plan savings, would it be able to generate due to the increased competition efficiency under private plans. And, Mr. Vladek mentions that typically the cost of 15 to 20 percent of the total cost.

I know that traditional fee-for-service Medicare has about a 2-percent overhead, and not only Mr. Feldman, but anyone, how can we—how can the fee-for-service, the 2 percent, compare with the Medicare+Choice or the proposals when we have to take 15 to 20 percent of it for administrative costs?

Mr. FELDMAN. Sir, I'd like to respond. I can design a system that has no administrative costs or virtually none. Providers submit

bills electronically, and the insurance company automatically pays them, but no one would want that system. We need some administration, the question is how much.

Mr. GREEN. Does CMS provide that administration now, because I know there are doctors' bills that are submitted to CMS that don't get paid.

Mr. FELDMAN. I don't believe that CMS provides enough administration now. Granted that HMOs take ten or 15 percent off the top, but let's look at what the HMOs in the Medicare program have been able to provide in the way of extra benefits that fee-for-service Medicare can't provide in their areas. That suggests that the administration cost is not eating up the total difference in the payment rates for those HMOs.

Mr. GREEN. Well, go ahead, anyone else to address the 15 to 20 percent administrative costs, considering 2 percent for fee-for-service?

Mr. VLADEK. I would just point out that the addition, as every member of this subcommittee knows, the additional benefits provided by Medicare+Choice plans are provided to beneficiaries only in some communities and not in others.

And again, that has to do with the extent to which the inadequate payment structure that we have for Medicare+Choice, which replaced a differently inadequate payment structure we had under the Balanced Budget Act, produces overpayment relative to fee-for-service in certain communities, which makes the provision of additional benefits by the plans affordable.

One of the places that couldn't make it under pre-BBA rates, and that has had a great deal of difficulty keeping private plans in the program since, is the place, the Twin Cities, where some of the most efficient and best managed care plans in the country are.

Mr. GREEN. Let me go on to my next question, since I only have 5 minutes.

Let me point out, fee-for-service Medicare can't provide additional benefits, because, you know, of law, whereas, a fee-for-service can, but again, the 15 percent, the 20 percent concerns me depletes its 2 percent to such a huge volume of the seniors who receive, you know, their traditional healthcare under fee-for-service.

Mr. Herman, let me ask you, on page three of your testimony you talked about discount cards alone, whether from the private sector or the public sector, does not equal coverage, is not a solution. And, I know in your testimony you talk about some of our pharmaceutical companies who have done, you know, they've created different cards in vacuum and jointly created one, and so your testimony is, is that discount cards alone can't provide the solution, whether it's by pharmaceutical companies, the proposal by the administration.

Mr. HERMAN. Yes, sir, that's correct. We need the ability to take care of prescription benefits. We've been waiting 37 years.

Mr. GREEN. Strictly under Medicare.

You mentioned also in your testimony on page five that HR4954, the one our committee spent a great deal of time on last year, one of the provisions in that, a volunteer affordable prescription provides permanent drug coverage while discounting medicine by as much as 60 to 85 percent. I have some concern about that, because

the bill that I remember spending many hours on talked about potential for discount, but I never saw it quantified. And, would that discount go to the PBMs as created by that legislation, or would it actually come back to where seniors would see their prescriptions reduced, or maybe the taxpayers would see what we provide for Medicare?

Mr. HERMAN. We saw that as the seniors themselves and, ultimately, the taxpayers, one evolves to the other.

Mr. GREEN. Okay.

Again, during a lot of our testimony and our long all-night debate I don't remember hearing a quantification of 68, I think that's what our provisions I would like to see, because we've seen success whether it's veterans, whether it's, you know, the Federal health insurance, whether it's, I know up on the board the State of Texas employees actually can provide prescription drug benefits, and also because of their negotiation ability.

Thank you, Mr. Chairman.

Mr. NORWOOD [presiding]. Thank you, Mr. Green.

I think it's important that the record state that Mr. Vladek said that the inadequate payment structure is why Medicare+Choice doesn't work, and it's important to understand that inadequate payment structure coming out of CMS is why we have so many physicians quitting Medicare today, it, basically, is not working in Medicare either.

I'd like to recognize now Chairman Barton for 8 minutes.

Mr. BARTON. Thank you.

My good friend and former Senator Phil Graham used to say, "We all want to get to heaven, we just all don't want to do what you have to do to get there." And, I think that's kind of where we are in the prescription drug benefit for Medicare.

I want the panel to stand up and look at the audience, just look behind you. Just stand up and look behind you, very briefly. Now, how many people out there do you all see that appear to be 65 or older? A handful maybe.

Mr. BROWN. How many do you see up here?

Mr. BARTON. If Chairman Bilirakis were here, I think Chairman Bilirakis would be close to it.

Well, here's the deal, if you polled the people up here we all want a prescription drug benefit for senior citizens. We voted on the House floor last night, we had three suspension votes. We named two post offices and passed a resolution, I think, in support of youth literacy. I think they were all unanimous, because there's no cost to it. It was a good thing to do, and there was no cost to it.

But, the test on a prescription drug benefit, in the current Medicare system, or even reforming Medicare system, is not just to provide an adequate benefit that our friends at AARP are going to support, but to make sure that all those people sitting out there behind you have a benefit when it gets to be their turn. In other words, we have to try to come up with a defined benefit that doesn't break the bank on down the road. And, that's why not one of you, not one of this panel in your opening statement, proposed a solution. Not one of the experts proposed a solution.

Now, here's the AARP solution, implicitly, not explicitly, you want a universal benefit. You want a catastrophic stop loss that's

not more than $3,000. You want a premium that's not more than $35. You'd prefer a deductible that's not more than $100 on an annual basis. You don't want any donuts in your coverage, and you'd like a discount card that's going to have a prescription drug discount card that's at least 40 to 50 percent.

And, on page seven, and I quote, you want enough money, "Enough money is available in the budget to accomplish this goal." That's a solution, except that they don't say what the amount of the money is.

Now, Mr. Olsen, you are a great guy, and you have obviously been very well coached, or you are just naturally a very good speaker in presenting your positions. Does AARP, based on your testimony, have an estimate of what that prescription drug benefit plan would cost on an annual basis, because you outline it, universal coverage, catastrophic stop loss not more than $3,000, premium not more than $35, deductible not more than $100, no donuts, and a discount card that gives at least 40 to 50 percent discount.

Mr. OLSEN. First of all, thank you for the compliment, but I'm not sure——

Mr. BARTON. It is. I want you to testify for me if I'm ever before a Grand Jury.

Mr. OLSEN. We believe the debate last year clearly showed that $400 billion over 10 years is not enough.

Mr. BARTON. I didn't ask that question.

Mr. OLSEN. I understand that.

We do not have a number we can give you, it will depend on how all these elements are put together, and we will be happy when the structure has started to coalesce to work with the committee and develop a bipartisan approach.

Mr. BARTON. Then, let me rephrase the question. How much do you think the people behind me should be willing to pay starting next year and every year thereafter, adjusted for inflation, what's fair to them?

Mr. OLSEN. Our——

Mr. BARTON. $40 billion a year is not enough, how much is enough that provides a benefit that you would prefer for the AARP'ers, that they can afford to pay, and understand this, once they start paying it they are going to pay it every year the rest of their working lives. The young man in the green suit, the young lady in the red sweater, the young man over here in the black suit, they are going to pay it the next 30 to 40 years.

Mr. OLSEN. First of all, the people in the back of the room are probably the ingenious ones that are going to figure out how it will be done, let's start on that one.

But, I would, and maybe they should be up here testifying, I am a beneficiary myself now, I used to be——

Mr. BARTON. And, we want you to continue to be a beneficiary for a long time.

Mr. OLSEN. [continuing] one of those folks sitting in the back of the room, my reaction was that I was taking care of my parents, so that I did not have to do it myself. It's an intergenerational thing. Our research shows that there's great support among the

people under 65 for a prescription drug program that is affordable, it's meaningful, and it's available, and you don't——

Mr. BARTON. I've got all that. I understand that. I didn't hear an answer.

Now then, but you said something that I want to ask everybody on the panel. I'm a part of the task force that's trying to come up with some innovative ways to, perhaps, solve this. How would you folks react if the Congress passed a law that said, any family member that buys a prescription drug for their mother, their father, or anybody over 65, their aunt, their great aunt, could fully deduct it from the cost of their taxes if they owed taxes, and if they didn't owe taxes get an earned income credit for it?

Mr. OLSEN. It's never occurred to me, so I couldn't respond.

Mr. BARTON. Well, be a human being, think without getting briefed on it. What do you all think about that? I just—my mother was in the hospital 2 years ago, when I got her out of the hospital I went down to the hospital pharmacy, I paid $247 bucks for her initial prescriptions. I don't know if I could deduct that from my taxes the year after that.

Mr. OLSEN. Again, it gets to what are the merits of the drugs you bought for your parents, as opposed to those you buy for yourself. The out-of-pocket nationally——

Mr. BARTON. I'm not 65 yet, I hope to be 65 in 1 year.

Mr. OLSEN. But, you'll pay 40 cents out of your pocket for your parents and 33 cents out of your pocket for yourself and your kids.

Mr. BARTON. Well, look guys, I'm getting back to what I said at the beginning, we all want to get to heaven, but none of us want to do what it takes to get there. The Federal Government cannot afford a prescription drug benefit that AARP is just going to hug to death and say it's great.

Now, we might be able to afford something that you all accept grudgingly, kind of behind the back, or, you know, if that's the best we can do, but we should be family friendly. Why would it be wrong to say if my mother is on Medicare and needs prescription drugs, and there's not a prescription drug benefit and I buy them for her I can deduct dollar 1, all those costs, up to some amount, what's wrong with that? It doesn't cost the tax—it's a tax credit next year. I bet the answer is, there's some seniors that don't have children that could do it, so then how do you take care of that? Then you let non-profit charities. If you wanted to be really creative about it, you'd say let churches, but heaven help us to get started in that debate, just say non-profit charities, to think about it. We need some innovative solutions.

Mr. FELDMAN. Mr. Barton, I'm a little bit reluctant to get into the debate with you, I'm afraid I'm going to lose.

Mr. BARTON. That's okay with me.

Mr. FELDMAN. I like, I think your idea is very similar to an insurance policy for drugs, which has the government pick up a certain proportion of the cost, and I like it for that reason. But, where I think it falls down is for the people who have very high costs who really need the insurance, you still are only paying them 30 or 40 percent of the cost, instead of even as I understand the last Republican proposal there was a $3,700 cap. So, I'm worried that your proposal doesn't have——

Mr. BILIRAKIS. I thank the gentleman. The time, I'm sorry, has expired.

Mr. Strickland, you are recognized for 5 minutes.

Mr. STRICKLAND. Thank you, Mr. Chairman, and I have an answer for my friend from Texas, as to how we can do what AARP wants or come close to doing it. What about $726 billion? That would go a long way toward accomplishing what AARP——

Mr. BARTON. You just happened to pull that number out of the air?

Mr. STRICKLAND. I just happened to pull that out of the air, and I'd like to say to all those young people back there, if they make less than $1 million a year it will cost them very little.

And, I'm being a little facetious, but I'm also trying to illustrate something that I think is accurate. We are not talking about money here, we are talking about values. Do we have the will to do what we've all told the American people we want to do for them?

When it comes to the national security of this Nation, we say there are no limits that we will not go to achieve safety and security for our people. Well, we are talking about health security, and it seems to me that we need the same kind of attitude about prescription drug coverage.

I believe that we don't argue here between parties or among those of us with different philosophical points of view about the size of the pie. I think we argue about how that pie is going to be cut up, and who is going to get the larger pieces, and I'm talking in terms of our Federal resources.

So, we find money to do that which we truly believe is worthy of being done. I believe that, and I will challenge any of my colleagues to take a different point of view. When we are fighting a war, we say we will do whatever it takes. There are no limits to our national will, to spend money, or to do whatever it takes to get the job done. But, when it comes to the health and security of the American people we have a different set of values. That's where we are.

Question for Mr Vladek, I hope I'm pronouncing that reasonably correctly. I heard a lot that we need to improve Medicare so that beneficiaries can have better disease management. Now, the Bush Medicare proposal gives a more generous drug benefit and better preventive benefits in private plans and not in Medicare, but I'm wondering whether we really need private plans to do what needs to be done in terms of these improvements.

Do we have an definitive evidence that HMOs or private plans do better with respect to quality than Medicare? I know there has been some work done that shows in several instances Medicare beneficiaries with chronic conditions in HMOs show a worse quality of care than those in regular Medicare. Can you respond to that, please?

Mr. VLADEK. Thank you, sir.

I think it's fair to say that the evidence is fragmentary and spotty, but when talking about the management of chronic illnesses, or the treatment of Medicare beneficiaries with chronic diseases, I don't even want to say as much, because it's all over the place, but there is evidence that managed care plans have done less well, and

there is some anecdotal evidence that they've done as well or better.

The most recent published data on quality of care for Medicare beneficiaries looked at the fee-for-service sector, which showed really quite substantial improvements in the quality of care provided to Medicare beneficiaries and Medicare fee-for-service in the 1990's, and I'm not familiar with any data from the managed care sector for the Medicare population, or any other population that shows qualitative improvements quite as dramatic as the Jinx article in JAMA several months ago.

Mr. STRICKLAND. Thank you.

I'd like to say to Mr. Feldman, who indicated the improved services or enriched services that are possible through Medicare+Choice. That may be true if you have Medicare+Choice options available to your constituents. In southeastern Ohio they are gone, and so that's not an option for most of the people that I represent.

One follow-up question, Mr. Vladek. If it is true that private plans don't have documentation, or we don't have data to suggest that they do better quality of care, or even as good, why don't we just give Medicare the tools that they need to do better disease management activities? Why only give private plans these tools and these extra benefits, why not give them to Medicare as well? I just don't understand why we wouldn't choose to handle Medicare with the same level as we do these private plans.

Mr. BILIRAKIS. It's a good question. The gentleman's time is expired.

Bruce, if you have just a few minutes to respond to that, we'd like to hear it.

Mr. VLADEK. Very briefly, the most effective disease management programs, the most important thing they do, which Medicare doesn't now do, is pay for prescription drugs. For congestive heart failure, for diabetes, for the other places where disease management has been most effective the key is the drugs, and the rest of it is cheap and largely peripheral.

Mr. STRICKLAND. Thank you, Mr. Chairman, for giving me those extra few moments.

Mr. BILIRAKIS. Mr. Buyer, to inquire, for 5 minutes.

Mr. BUYER. Thank you.

First I'd like to thank Doctor Crippen and Mr. Vladek for your services and contributions to your country.

This is my 11th year here on Capitol Hill, and I've spent a lot of time in the VA health delivery system, and as the chairman for 4 years over the military health delivery system, and 3 years to design, do the pharmacy redesign, that was far easier than this.

Now, as I am learning more about the intricacies of Medicaid and Medicare, as we try to perfect these systems I still come with a market-based approach. I still believe in the innovations out there, but I'm a little concerned. I'm concerned because I don't want to make changes, give improvements to a model that I know is going to crash in the future. I'm very concerned.

And, I want to get a quick feeling for the opinions of everyone here, since I don't have much time, I only have 4 minutes, there have been some recommendations with regard to reforms in Medi-

care itself. I'd like to know how your support is, let's go down the line, who here would support increasing the program's eligibility age. Since Congress addressed this back in 1983 they increased it for Social Security but not for Medicare. Let's go right down the line. Who would support increasing the age to make Medicare match Social Security, to age 67?

Doctor Crippen?

Mr. CRIPPEN. I think it's an inevitable we'll end up there some day, particularly if we enhance disability.

Mr. BUYER. Doctor Feldman?

Mr. FELDMAN. I think we are going to have to face that choice. What you are talking about here——

Mr. BUYER. I don't have that kind of time.

Mr. FELDMAN. Excuse me.

Mr. BUYER. All I need from you is whether you support that or not.

Mr. Herman?

Mr. HERMAN. Yes.

Mr. BUYER. Mr. Vladek?

Mr. VLADEK. If you really match it to Social Security and let people collect something at 62.

Mr. BUYER. That's not the question now. Would you support what has been proposed?

Mr. VLADEK. I would match it to Social Security for eligibility age, both for full benefits and reduced benefits.

Mr. BUYER. That's an answer.

Mr. Olsen?

Mr. OLSEN. My answer would be, I do not favor that. It's come to occur to me that——

Mr. BUYER. All right, let me ask a second question then.

With regard to, I guess AARP doesn't like the terms means tested, but whether it's means testing or income relation, with regard to Part B would you support doing that?

Doctor Crippen? Examining means testing or income relation.

Mr. CRIPPEN. Yes.

Mr. BUYER. Medicare Part B.

Mr. OLSEN. By the way, we did that in '88 and it's one of the things that probably killed the program.

Mr. BUYER. Is that true, Mr. Feldman?

Mr. FELDMAN. I know the very short answer is yes.

Mr. BUYER. Thank you.

Mr. Herman?

Mr. HERMAN. I'd have to get back to you, I'm not sure.

Mr. VLADEK. Yes, just as we supported it in '97.

Mr. BUYER. Thank you.

Mr. Olsen?

Mr. OLSEN. Well, I've already answered.

Mr. BUYER. You said that you would support.

Mr. OLSEN. We absolutely want to discuss the income relating and to finish my last question——

Mr. BUYER. I can't, I haven't got time.

With regard to increasing the beneficiary cost sharing, if we increase Part B co-insurance 20 to 25 percent, or Part B deductibles

from $100 to make them compatible with the private sector, is this an alternative that we should be examining?

Doctor Crippen?

Mr. CRIPPEN. Yes, increase the deductible.

Mr. BUYER. Thank you.

Yes on both? I'm sorry, Mr. Herman was yes on both.

Mr. Vladek?

Mr. VLADEK. I would say no on both.

Mr. BUYER. You'd say no on both?

Mr. VLADEK. That's correct.

Mr. BUYER. Wow.

Mr. VLADEK. I think they are interrelated questions of the total program. You can't make an answer until you see the total structure.

Mr. BUYER. With regard to the fourth question, introducing market-based innovations into the current fee-for-service program, whether it would be case management programs for heart disease, chronic pain, diabetes, would everyone concur? Can we find some middle ground here? Everyone concurs in the positive. The record will reflect that.

With regard to major structural reforms, there have been suggestions with regard to combining Parts A and B of the program for a single deductible of up to $400. It was introduced by the Breaux/Thomas proposal.

Doctor Crippen, would you support this?

Mr. CRIPPEN. I don't think that's a major reform.

Mr. BUYER. Yes, would you support that? You would.

Mr. Herman, would you support it?

Mr. HERMAN. Yes.

Mr. BUYER. Mr. Vladek, with A and B?

Mr. VLADEK. I would support that.

Mr. BUYER. You would support that.

Mr. Olsen?

Mr. OLSEN. At this time.

Mr. BUYER. At this time. So, it's something the AARP may, in fact, support in the future, if you find yourself the only one saying no?

Mr. OLSEN. We want the whole subject open for bipartisan discussion.

Mr. BUYER. The Breaux/Thomas proposal was bipartisan, through a bipartisan commission, was it not?

Mr. OLSEN. Yes.

Mr. BUYER. Thank you.

I'll yield back my time.

Mr. BILIRAKIS. Thank you, sir.

I recognize Mr. Burr for 5 minutes.

Mr. BURR. Mr. Chairman, do I get extra time since I did not give an opening statement?

Mr. BILIRAKIS. You have to be here, Mr. Vice Chairman of the committee.

Mr. BURR. The chairman cannot fault me for trying.

Bruce, welcome, Dan, as well as our other distinguished panelists. It troubles me slightly to see the lack of a crowd in this hearing room and the lack of press representation, because, honestly,

I can't think of an issue that's more important than what we are setting out to do.

Mr. Olsen, I'm delighted to hear that AARP would like to see something. We want to pass something that's signed into law, and I think that what you need for a product to do that is willing partners. And, I think for once we have enough willing partners at the table.

Let me launch into a few questions, if I can.

Dan, you very specifically covered three items in your testimony that I think you predicted would happen, or the budgetary one, that we would need to borrow the equivalent of a trillion dollars a year to virtually eliminate the rest of government, including education, defense and all the rest. Three, raise taxes by something like 10 percent of GDP, if we were able to afford this in the future.

And, I guess my question, quite frankly, is, have you taken into account growing the economy as an option, and could we grow the economy sufficiently to support this type of cost?

Mr. FELDMAN. Those numbers actually include about a 3-percent real growth a year, so there's an assumption that the economy does keep growing, but you could not grow your way out of this, no. I mean, the fact that we are going to double the number of retirees without changing much the size of our work force makes it impossible to do that.

Mr. BURR. But, could you grow the economy and reform the system in a way that financially you could keep the promises?

Mr. FELDMAN. You'd have to do both, yes.

Mr. BURR. You said it was easy to construct a $900 billion plan, much of the $900 billion is currently being paid by somebody. How much, in your prediction, is currently being paid for?

Mr. FELDMAN. I'll have to rely on my old colleagues here, they know a lot more than I do, frankly, the current assumption, baseline, it's $1.8 trillion over this 10 years. The $900 number I picked just as being roughly half of that. My point was, it's easy to figure out how to spend the $900 billion as a Federal benefit. That's not the hard thing to do, it's how you are going to target that to folks who now are not getting drugs or can't afford it.

Mr. BURR. But, my question was, how much, you said an ideal plan you could design is $900 billion, but much of that is already being paid for by somebody.

Mr. FELDMAN. Right.

Mr. BURR. How much is—well, actually——

Mr. FELDMAN. Some of the plans that we looked at at CBO in the past, some of them would say that we could spend less than $900 billion with a Federal benefit if it had a lot of——

Mr. BURR. No, but how much is currently being spent in the population by somebody?

Mr. FELDMAN. The entire amount, almost the entire amount.

Mr. BURR. There's currently a drug expense that people are paying, somebody is paying, out of their pocket, out of a plan, out of the State Medicaid. How large a pot of money is that today? Is it $900 billion?

Mr. FELDMAN. No, it's actually twice that, $1.8 trillion.

Mr. BURR. Okay, thank you.

Mr. Olsen, if the plan provided health to the most at risk, meaning that we have targeted those low-income individuals, and assume for the purposes of this discussion that we said we're going to pay 100 percent of your drug costs, and there were a separate policy that dealt with catastrophic. So, in other words, people above a certain income line were not provided first dollar drug coverage, but they were provided a policy for catastrophic los, would AARP be supportive of that approach?

Mr. OLSEN. Going back to my testimony, I think it's five elements that I thought were critical, and those are two of them, the low-income assistance program outside of Medicare, which you indicated, and a catastrophic.

In addition, we would hope that the structure would include also the other elements that we indicated, which is, you know, affordable prices and available to everyone, and a stability from year to year.

So, those are two of the elements that we consider very important, but we don't think that gets us there.

Mr. BURR. Let me cut you short, though.

Mr. OLSEN. We don't think that's where we need to go.

Mr. BURR. I've got 2 seconds.

Is there anybody on the panel that feels that to provide a low-income drug benefit, that it has to have an insurance product to provide it?

Mr. VLADEK. I'm sorry, with the time, as opposed to what, as opposed to a direct provision by purchase from the manufacturers and delivery by the government?

Mr. BURR. We have a whole world of options that don't demand that there be an insurance product to supply something that the Federal Government is saying we are picking up 100 percent of the tab, so I guess for the purposes of Dan's world that he deals in, could we self-insure a defined population without bringing a third party insurer into that?

Mr. FELDMAN. Sure.

Mr. NORWOOD [presiding]. Thank you, Mr. Chairman, and let me suggest that is an important question, and, perhaps, you would be kind enough to respond to the committee in writing on that.

I recognize Mr. Deal for 5 minutes.

Mr. DEAL. Mr. Chairman, first of all, I will yield back to you for a question you wanted to ask.

Mr. NORWOOD. Thank you, Mr. Deal.

Mr. Olsen, after reading your testimony and hearing then Chairman Barton outline what you recommend as a plan, does that mean that the AARP doesn't any longer support the Graham/Smith bill that came out last year? My understanding was you did support that, it's about low-income and catastrophic, and does that mean you've got a change of heart this year?

Mr. OLSEN. You'll pardon me, I'm not an expert on policy, so I don't remember the exact details, but in my recollection there was a gap in there, and our current policy is one that everyone would have, you know, it would be available to everyone in the program. So, that's our position.

Mr. NORWOOD. So, your policy this year is different than at that point last year that Mr. Graham and Mr. Smith altered their bill?

Mr. OLSEN. I don't recall the specifics of that bill, I'm sorry.

Mr. NORWOOD. Would you give me an answer to that in writing?

Mr. OLSEN. I'll absolutely do that.

Mr. NORWOOD. Thank you very much, Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman.

I'd like to ask just a couple of rather quick questions, hopefully. One is, have there been any study done on whether or not we could achieve a satisfactory result and achieve a satisfactory cost line by simply restricting the formularies that are available? In other words, rather than across the board have a restricted formulary, and if you have any information on that would you comment?

Mr. FELDMAN. Sir, I think it depends on what you mean by satisfactory. It's not going to reduce the trend of drug costs, which, ultimately, is going to be driven by technology and an aging population.

However, it can get us the drugs at a lower cost than we could get them without a formulary. Estimates for two-tier formularies suggests that the savings are a couple percent. Estimates for the three-tier formularies, which is the most common design now in the private sector, range from five to 9 percent.

Mr. DEAL. Anyone else?

Mr. VLADEK. I believe in the Medicaid law, the adoption by States of formularies produced savings of that magnitude or somewhat more, low double-digit percentages over what they otherwise would have paid.

Mr. DEAL. Those formularies adopted under Medicaid at the State levels, have there been any significant complaints with regard to those formulary approaches?

Mr. VLADEK. There have been very, very significant complaints. How valid the complaints have been I couldn't totally comment on.

Mr. DEAL. Is that mostly from somebody who wasn't in the formulary?

Mr. VLADEK. Or particular beneficiaries who have become attached for whatever reason to a particular drug that's not in the formulary.

Mr. HERMAN. Formularies can be extremely difficult for senior citizens. You are telling them that you've got to take this, here it is, you come back, you've got the side effects that occur with that, now you've got to get another one, you are not particularly mobile. Even at our age, I ran into formulary problems with an HMO. I went through four different drugs, the number of times I had to go back in there and get permission to get something else was ridiculous for just hypertension.

You start spreading that over a population that isn't mobile, and that isn't really very effective, but it's darn sure harmful.

Mr. DEAL. Yes, sir.

Mr. OLSEN. I think we realize that there needs to be a professionally developed, something called a formulary or something, we just think it's critical that whatever is in there has some kind of an appeal or an escape mechanism so that when what was just described happens there is a quick way to appeal and out of that.

Mr. DEAL. Okay.

With regard to the purchasing mechanism for this, we've all had the complaints from our small local pharmacist that whatever plan

we adopt they are going to be left out of the process. Would any of you comment with regard to a purchasing arrangement, if it were not privately handled, a purchasing arrangement that would maybe track what we have at VA and other Federal agencies that have mass purchasing processes in place, is that something that—what has been the thought process that's been given, if any, to a mass purchasing of drugs through some government entity that would maybe follow the pattern of VA and other Federal agencies?

Mr. HERMAN. Our members want choice. They want the ability to go to their local pharmacist, or their mailbox, depending on what the situation is. The mass buying side of this opens up a giant can of worms. On the one hand, you start hearing, well, that's going to stop R&D, and on the other hand you hear nothing ever stops R&D. But, we would say that when you start getting into mass buying, price control, which is really what you are getting into, that you do stop a portion of R&D, and it's the portion of R&D that isn't the most profitable. So, you now have drug companies that will have a profit motive, and they'll be looking at 15 items, and they'll exclude three of them because they are going to be under a cap and there's no money in that. So, let's go over here and look at the cancer drug and ignore the Alzheimer's drug.

So, from a standpoint of that kind of buying, you are not going to stop R&D, but you may well stop significant R&D for senior citizens.

Mr. DEAL. I think my time—Dan, do you have a comment?

Mr. FELDMAN. I was just going to say that dispensing is a separable issue, I think, from the purchasing, and in competition, and negotiable ought to be dispensing fees like everything else. The friends at the other end of the table, AARP, are one of the largest distributors of pharmaceuticals today through the mail, so there are lots of ways that this may be cracked, but there's always a place for a distribution system separate from the purchasing.

Mr. DEAL. Okay, thank you.

Thank you, Mr. Chairman.

Mr. NORWOOD. Thank the gentleman.

Mr. Allen, you are now recognized for 5 minutes.

Mr. ALLEN. Mr. Chairman, thank you. I appreciate the courtesy of being able to participate in this hearing. I thank you all for testifying.

Just a few comments and then a question. I think the bill that I had would contain costs as much as any bill in the Congress, costs of prescription drugs for seniors, so I care about cost control. But, I'm struck by the fact that many people who talk about the cost of this system and how much it will cost in the future never talk about the added value to seniors. And, I just think we ought to remember that if we do this and get it right, whichever way it is, the health of our seniors will be a lot better than it is today.

Second, Medicare+Choice is always thrown up, those who advocate private plans will talk about Medicare+Choice. This is just an anecdote, I'm not relying on it, but my parents were on Medicare+Choice in their mid 80's, they are both gone now, but it was a nightmare. It was an absolute horrific nightmare, because no matter what procedure they went for the claim was denied and we had to go back to my father's law firm and they had to somehow

manage the claim. And, the prospect of seniors, you know, trying to cope with a private plan has always struck me as being a problem.

There are those who hold up the FEHBP as a model. Well, I was looking at the 2003 handbook, and guess what, there is no, zero, there is no plan, an HMO plan or a point of service plan in the State of Maine for Federal employees, none. Just skimming through this, there are nine States where there is only one plan. The choice, I would argue, is often, appears to me, the choice from private sector involvement in many cases I think would be a myth and we'd get the kind of variation across the country that I think is a tremendous problem.

Mr. Vladek, I want to ask you a question about how well the private health care system is doing right now in the area of prescription drugs, because, of course, you have these private plans and the employer for people who are employed, and in many cases I think they work well, but when it comes to the companies, the entities which are managing these prescription drug plans for employers it seems to me there are a lot of problems.

A number of lawsuits have been filed against plans for negotiating hidden deals for their own benefit, at the expense of employers. Switching employees to higher priced drugs, for the benefit of the pharmacy, benefit manager, of they get kick backs from drug companies, or they fail to pass on millions of dollars in rebates and other financial incentives to employers that the PBMs then pocket for themselves.

I would just like, what I think is going on is that employers don't have the market power to leverage discounts from the manufacturers, so they hire these private companies, but the private companies strike their own deals with particular manufacturers.

Mr. Vladek, would you be able to comment on that, and talk a little bit about what those kinds of problems mean for a plan under Medicare that relies on private PBMs or on other such intermediaries?

Mr. VLADEK. Thank you, Mr. Allen.

In some of the details of the way the pharmaceutical industry, the wholesale and distribution industry is, Doctor Feldman probably knows more than I do, but I've had some exposure to it in recent months, and I've never seen anything as baroque, or as complicated, or as hidden, as the way in which prices and actual—both nominal prices and real prices are manipulated in the flow for the supply chain from the time it leaves the manufacturer to the time it reaches the retail consumer.

There are all kinds of rebates of shadow prices, of private deals and so on and so forth, and I think there's some major litigation now involving the PBMs for failure to disclose to their customers the fact that they were getting very substantial rebates for certain drugs, and, therefore, benefiting themselves rather than their customers in that regard.

I do think, to be very blunt about it, the issue of the PBMs and the private intermediaries has arisen because we've been unwilling politically to talk about government leverage over pharmaceutical prices in the Federal programs or in Medicare, while we are willing to talk about it for the VA, we are willing to talk about it for the

Public Health Service, or we are willing to talk about it in State Medicaid programs. But, that's what it comes down to.

And, if you need to disguise efforts to do something about price controls, then you need some kind of intermediary, but I'm not sure that the track record of any of the existing intermediaries is particularly encouraging in that regard.

Mr. ALLEN. I thank you.

Thank you, Mr. Chairman.

Mr. NORWOOD. Thank you very much, Mr. Allen.

Gentlemen of the panel, thank you for taking your time. We'll be anxiously looking forward to hearing from you and some of the questions that time didn't permit to be answered.

With that, this hearing is now adjourned.

[Whereupon, at 12:36 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF THE ALLIANCE TO IMPROVE MEDICARE

The Alliance to Improve Medicare (AIM) is pleased to submit this statement for the hearing record to the Energy & Commerce Health Subcommittee. We applaud the Subcommittee's continued dedication to improving and strengthening Medicare. AIM has developed a set of recommendations on providing access to prescription drug coverage though Medicare and we are pleased to share these recommendations with the Subcommittee. The recommendations provide guidance for developing prescription drug coverage through both the traditional fee-for-service Medicare program and Medicare's managed care program, Medicare+Choice.

Medicare was designed and created in 1965 when hospital-based care was the standard. Today's standard of care, however, includes a greater reliance upon modern technologies such as prescription drugs to treat patients and reduce the number and length of hospitalizations. Designed today, Medicare would no more exclude prescription drug coverage from the standard benefit package than it would exclude hospitalization or physician services. Current statistics show that nearly one-third of Medicare's elderly and disabled beneficiaries lack outpatient (Part B) prescription drug coverage. The balance of Medicare beneficiaries have some level of coverage through retiree health benefits, Medigap policies, Medicare+Choice plans or Medicaid.

AIM believes all Medicare beneficiaries should be offered prescription drug benefits as an integral part of Medicare health coverage and as part of broader efforts to strengthen and improve both the traditional fee-for-service program and Medicare's managed care program, Medicare+Choice. Further, AIM believes prescription drug benefits should be designed with adequate financial support and effective management tools to ensure reliable coverage and long-term success. AIM also believes that equal financial resources should be dedicated to both the fee-for-service program and the Medicare+Choice program for the development of prescription drug benefits. Finally, AIM believes health plans should have flexibility in designing prescription drug coverage benefits and opposes bureaucratic prescription drug proposals and government price controls.

Prescription Drug Coverage in Fee-For-Service Medicare

AIM believes fee-for-service Medicare beneficiaries should have private health care coverage options that include prescription drug coverage as part of the basic benefit package. AIM supports efforts to add prescription drug coverage to the fee-for-service benefit package through a new, comprehensive benefit package. Medicare fee-for-service program beneficiaries should have a comprehensive benefit package that includes basic prescription drug coverage.

Further, a comprehensive benefit package in fee-for-service Medicare should include appropriate use of private sector management tools. Private sector health plans have developed proven tools to ensure safe and cost effective use of prescription drugs. These management tools, including formularies, tiered co-payments, and drug interaction prevention programs, are essential to high-quality coverage for beneficiaries and should be incorporated into a new comprehensive, fee-for-service benefit package while allowing access to all classes of drugs.

Finally, a fee-for-service benefit package that includes prescription drug coverage should avoid government imposed price controls.

Prescription Drug Coverage in Medicare+Choice

Congress created the Medicare+Choice program as a health care coverage option for Medicare beneficiaries. The option was designed to offer more health care coverage choices and organized health care systems to beneficiaries. However, Medicare reimbursements which fall below cost increases, severe payment cuts, and increased costs due to excessive regulation have caused many Medicare+Choice plans to reduce or eliminate prescription drug coverage in order to maintain plan offerings in some counties.

AIM's recommendations to ensure prescription drug coverage for Medicare+Choice program beneficiaries require adequate payments to all providers. The current Medicare+Choice payment formula has resulted in inadequate payment levels which have not kept pace with overall medical costs for Medicare+Choice plans in many parts of the country. Stabilization of the Medicare+Choice program will minimize disruption of benefits, including prescription drug benefits, among beneficiaries. Recent reductions in funding for Medicare+Choice health plans have caused many plans to reduce the scope of their prescription drug benefits or to increase beneficiary cost sharing.

Further, AIM believes that Congress must ensure a sustainable funding and financing mechanism for a prescription drug benefit. The additional Medicare program costs associated with providing prescription drug benefits should be accompanied by a reliable and sustainable financing mechanism.

Finally, health plans must be allowed flexibility in the design of benefits packages. Beneficiaries should have the option of selecting from among many different plans and plan types to best suit their own coverage needs. Statutorily mandated benefit requirements will unnecessarily restrict beneficiary options for coverage.

Conclusion

AIM appreciates the opportunity to provide these comments to the Health Subcommittee and applauds Chairman Bilirakis for his efforts to improve Medicare. AIM urges the Subcommittee to consider these recommendations to ensure a sustainable Medicare prescription drug benefit for all Medicare beneficiaries. We look forward to working with the Subcommittee and other members to further improve and strengthen Medicare this year.

PREPARED STATEMENT OF DAVID G. SCHULKE, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH QUALITY ASSOCIATION

The American Health Quality Association represents independent private organizations—known as Quality Improvement Organizations (QIOs)—that work under contracts with the Centers for Medicare and Medicaid Services (CMS) to improve the quality of care for Medicare beneficiaries in all 50 states and every U.S. territory. Congress created the QIOs to monitor and improve the quality of care delivered to Medicare beneficiaries and supports the national work of the QIOs with approximately $333 million annually from the Medicare Trust Fund, or about $8 per beneficiary per year.

Past policy efforts to develop a Medicare prescription drug benefit for the 21st century have focused almost exclusively on financing a benefit. Very little attention was given to including initiatives in the drug benefit to ensure a benefit is safe and continuously monitored to maximize the quality of outpatient pharmacotherapy.

In the 107th Congress the Energy and Commerce Committee became the first congressional committee to recognize this challenge by including language in House Report 107-551 directing the administrator of the Medicare prescription drug benefit to make Part D claims available to QIOs for quality improvement efforts. The American Health Quality Association commends the Energy and Commerce Committee for their leadership in this regard. It is absolutely critical to create an integrated quality improvement program. Otherwise, beneficiaries are likely to be ill-served by a carved-out drug benefit that operates separately from the Medicare hospital and outpatient benefits and data systems.

BUILDING A SAFE DRUG BENEFIT.

A Medicare outpatient prescription drug benefit presents an opportunity to improve the quality of life for our nation's seniors, but also brings the real risk of increased morbidity and mortality associated with an increase in the use of medications. It is reasonable to predict that with an outpatient prescription drug benefit, more seniors will receive more drugs. Expanding access to and availability of drugs, without a complementary investment in quality improvement, will exacerbate the unacceptable cost and incidence of hospital and long-term care admissions associ-

ated with medication use. A recent meta-analysis of 11 different studies reviewing drug use in the elderly population found that "[t]he reported prevalence of elderly patients using at least one inappropriately prescribed drug ranged from a high of 40% for a population of nursing home patients to 21.3% for community-dwelling patients over age 65." [1]

Pharmacoeconomists at The University of Arizona have tracked the costs associated with drug therapy since the early 1990s.[2,3] In the spring of 2001 these researchers published the following statement: "Overall, the cost of drug-related morbidity and mortality [in the ambulatory care environment] in the United States exceeded $177.4 billion in 2000. Hospital admissions accounted for nearly 70% ($121.5 billion) of total costs, followed by long-term-care admissions, which accounted for 18% ($32.8 billion)." [4]

INTEGRATING MEDICAL AND PHARMACY DATA SYSTEMS THROUGH MEDICARE QIOS.

Historically, attempts to address the morbidity and mortality associated with medication use have been stymied by the inability of practitioners in various disciplines to access certain medical or pharmacy records that would otherwise provide a comprehensive picture of a patient's true medication use history. As this committee discusses building a Medicare prescription drug benefit for the 21st century, it is essential that the new statutes and regulations include language that provide the QIOs with access to pharmacy claims data. Regardless of how a drug benefit is administered, the Secretary of HHS must have unrestricted access to pharmacy claims data to use in directing the activities of the QIOs. QIOs were created by Congress with the necessary confidentiality protections and staff expertise to permit them to combine medical and pharmacy data to guide health care systems improvement.

Most congressional proposals forwarded to date rely on the pharmacy benefit administrators to process pharmacy claims data and take certain quality improvement steps at the point of service when the pharmacy claims data suggests medication misadventures. The good work of the pharmacy benefit administrators is limited by the information present in the pharmacy claim. Without integration of the data present in the medical record and pharmacy record, systematic failures leading to inappropriate prescribing and dispensing will continue to happen everyday.

INTEGRATION OF DATA SYSTEMS THROUGH QIOS IS CRITICAL—A STUDY OF OUTPATIENT BETA-BLOCKER USE IN HEART ATTACK VICTIMS.

QIOs use data to track progress and improve provider performance, reducing errors by focusing on treatment processes, mostly pharmacotherapy. Since 1996, QIOs have worked on local projects to improve clinical indicators in care for diseases and conditions that broadly afflict seniors. Among the diseases targeted for quality improvement by the QIOs, treating heart attack victims with beta-blockers offers an example of how the QIOs could further their current inpatient efforts with appropriate access to data gathered with an outpatient prescription drug benefit.

Medical practitioners have known for several decades that the secondary prevention benefits of beta-blocker therapy after heart attack include reduced hospital readmissions, reduced incidence of further heart attacks, and decreased overall mortality.[5] The evidence is so convincing that the American College of Cardiology and the American Heart Association guidelines for the management of heart attack recommend routine beta-blocker therapy for all patients without a contraindication.[6] Despite the evidence and expert recommendations, the use of beta blockers after heart attacks remains considerably suboptimal, with 20-30% of appropriate patients lacking this essential therapy.[7] The reason is unlikely to be cost. Beta-blocker therapy in the outpatient setting is one of the most affordable medications available to patients. A 90-day supply of this life-saving medication usually costs less than $10.00.

QIOs work to ensure that patients discharged from the hospital following a heart attack leave the hospital with a prescription for a beta-blocker. In the November 2002 issue of the *Journal of the American College of Cardiology* (JACC), researchers report that many patients never fill prescriptions for their discharge medication, and many of those that do discontinue the use of beta-blockers shortly after filling the prescription. The study's authors conclude: "Patients not discharged on beta-blockers are unlikely to be started on them as outpatients. For patients who are discharged on beta-blockers after AMI, there is a significant decline in use after discharge. Quality improvement efforts need to be focused on improving discharge planning and to continue these efforts after discharge." [8] During the QIO's Sixth Scope of Work (1999-2002), QIOs were responsible for improving the national rate of beta-blocker order at discharge by 7%.[9]

In his study published in JACC, Butler and colleagues found that the first step to preventing heart attack recurrence is to make sure a prescription is written and ordered at the time of the patient's discharge from a heart attack hospitalization. If this is done, the study shows there is a 10 TIMES greater likelihood of getting that patient started on inexpensive, effective beta blocker drugs that 20-30% of Medicare heart attack patients still do not receive, almost 40 years after the first marketing of propranolol, the first beta blocker.

The authors of the study utilized data for the dually enrolled population of patients (those receiving Medicare and Medicaid benefits simultaneously), as this is the only population of seniors for which there is comprehensive drug therapy claims data. This same kind of monitoring should be available for all beneficiaries. It is critical for Medicare to have the drug claims/ utilization data so QIOs can identify heart attack patients who don't fill a prescription for beta blockers post discharge, or who stop filling prescriptions (almost one quarter do after 6 months, according to the study)—and give their physicians assistance in getting the prescription started or changed (the latter might be needed if the patient didn't like the particular beta blocker initially prescribed and has consciously stopped taking it due to unacceptable or intolerable side effects). QIOs are ideally suited to identify patients at highest risk for hospital readmission or death due to poor beta-blocker adherence (i.e., patients taking beta-blockers post heart attack). We believe the QIOs unique ability to integrate medical information with pharmacy claims/utilization data complement pharmacy adherence programs that may be currently managed by benefit administrators.

QIO CONFIDENTIALITY REQUIREMENTS.

The confidentiality of information collected or developed by a Medicare QIO is assured by Section 1160 of the Social Security Act. It was the intent of Congress in drafting this provision to provide safeguards for information identifying a specific patient, practitioner or reviewer. These safeguards foster an environment that is conducive to quality improvement efforts.

RECOMMENDATIONS.

The American Health Quality Association has drafted the following legislative specifications we ask the Committee to include in this year's Medicare outpatient prescription drug benefit bill.

Legislative Specifications for the 108th Congress.

1) Give the QIOs responsibility for the outpatient drug benefit analogous to the responsibility they have for all other Title 18 benefits:

Add new 'Sec———— . Review Authority—. Section 1154(a)(1) is amended by adding 'and section ——— after '1876'.

2) Instruct the QIOs to make assistance available to providers, practitioners and benefit administrators to improve the quality of care under the new drug benefit.

Prescription Drug Therapy Quality Improvement.—Section 1154(a) is amended by adding a new paragraph 17:

"(17) With respect to items and services provided under Title XVIII Part ——— the organization shall execute its responsibilities under subsection (a)(1)(A) and (B) by making available to providers, practitioners and benefit administrators assistance in establishing quality improvement projects focused on prescription drug or drug-related therapies. For the purposes of this part and title XVIII, the functions described in this paragraph shall be treated as a review function."

3) Include legislative language instructing prescription drug benefit administrators to provide patient specific pharmacy claims and drug utilization data to the Secretary of HHS. Suggested wording:

"Requirements for Prescription Drug Plan Sponsors, Contracts, Establishment of Standards.—Any agreement between the Secretary and a benefit administrator for this purpose shall provide the Secretary with all patient specific pharmacy claims and drug utilization data."

4) Include legislative language providing appropriate availability of prescription drug claims data to the QIOs for quality improvement purposes. Suggested wording:

"Data Availability.—The Secretary shall provide the utilization and quality control peer review organizations with the patient specific pharmacy claims and drug utilization data to permit the organizations to perform the functions described in 1154(a)(17)."

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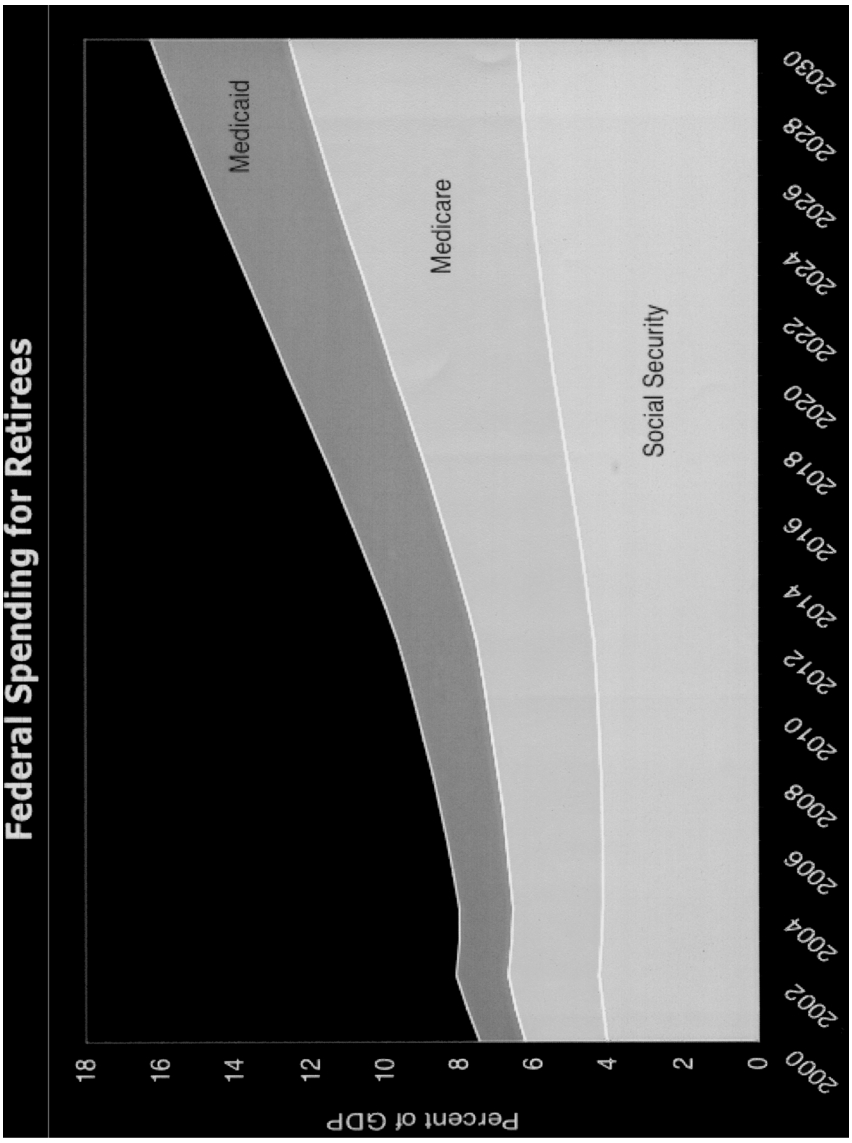
Medicare Beneficiary Drug Coverage, Use, and Average Price per Script By Type of Insurance Calendar Year 1999

	Number Benes		Ave. Scripts	
With Drug Coverage	30.2	75%	32	$45
Medicaid	6.4	16%	39	$40
Employer	11.9	30%	31	$55
Individual	4.5	11%	32	$41
Other Public	1.7	4%	37	$46
Medicare +	5.7	14%	28	$31
Without Coverage	10.1	25%	25	$37


Federal Spending for Retirees
Percent of GDP
18
16
14
12
10
8
6
4
2
0
2000
2002
2004
2006
2008
2010
2012
2014
2016
2018
2020
2022
2024
2026
2028
2030
Medicaid
Medicare
Social Security

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April 7, 2003

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The Honorable Michael Bilirakis
Chairman
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn H.O.B.
Washington, DC 20515

Dear Chairman Bilirakis:

On behalf of the Long Term Care Pharmacy Alliance, I am writing to submit this statement for the record of your Subcommittee's April 8, 2003 hearing on "Designing a Twenty-First Century Medicare Prescription Drug Benefit."

We appreciate your leadership in considering issues related to the creation of a new Medicare prescription drug benefit, and we would like to take this opportunity to highlight the special pharmacy needs of the nation's frail elderly residing in nursing facilities. We want to work constructively with you to ensure the continued provision of quality services to these particularly vulnerable seniors.

While most Medicare beneficiaries are able to walk into pharmacies to pick up their prescriptions or to receive vials of pills through the mail, a sizable percentage of beneficiaries cannot do so and need special services that retail and mail order pharmacies do not provide. Nursing home residents have specific diseases and multiple co-morbidities that require specialized pharmacy care. Without such treatment, we cannot expect positive therapeutic outcomes for these patients. Failure to take into consideration the special pharmacy needs of the frail and institutionalized elderly will lead to a marked increase in medication errors and other adverse events.

Pharmacy benefit managers and insurance companies are not equipped to administer a Medicare drug benefit to this vulnerable population, because they lack the necessary experience, infrastructure and expertise. By contrast, members of the Long Term Care Pharmacy Alliance are the nation's major operators of pharmacies that serve the frail and institutionalized elderly, and they specialize in serving the needs of patients in long-term care settings.

LTCPA members' patients are elderly, frail, chronically ill, and can no longer care for themselves. They require a level of pharmacy care that goes well beyond what the typical retail or mail order pharmacy provides to its customers. To meet these needs, long-term pharmacies provide specialized packaging, 24-hour delivery, intravenous and infusion therapy services, geriatric-specific formularies, clinical consultation and other services that are indispensable in the long-term care environment.

Without ensuring that nursing-home residents and other patients with special needs can receive these specialized pharmacy services, a Medicare prescription drug benefit could actually endanger the health of beneficiaries residing in nursing facilities. We look forward to working with you on a specific proposal to ensure appropriate coverage of pharmaceutical services for Medicare beneficiaries who reside in nursing homes.

If you have any questions or would like additional information, please feel free to contact me at (202) 457-6000. Thank you for your consideration of our views.

Very sincerely yours,

John F. Jonas
Patton Boggs LLP
For the Long Term Care Pharmacy Alliance

cc: The Honorable Sherrod Brown
The Honorable W.J. "Billy" Tauzin
The Honorable John D. Dingell

Mr. Chairman, for the Record

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Revised March 20, 2003

Cost of Administration Tax Cuts Exceeds the Combined Long-term Deficits Faced by Social Security and Medicare

The full report can be viewed at http://www.cbpp.org/3-5-03bud.htm

The Center on Budget and Policy Priorities has released a new analysis, *The Administration's Tax Cuts and the Long-Term Budget Outlook,* by Brookings Institution Senior Fellow Peter Orszag and the Center's Richard Kogan and Robert Greenstein. The analysis compares the long-term cost of the Administration's proposed and enacted tax cuts (the costs over 75 years) to the projected long-term actuarial deficit in Social Security and to the combined deficit faced by Social Security and the Medicare Hospital Insurance program. It finds:

- **The tax cuts would be more than three times as large as the Social Security shortfall.** The Administration's tax proposals include making the 2001 tax cut permanent, enacting tax breaks for dividends, creating new tax-free savings accounts, and various other tax cuts, some of which are part of a "growth" package. If all of these proposals are enacted, the cost of these proposals and the tax cuts enacted in the Administration's first two years would be between 2.3 percent and 2.7 percent of Gross Domestic Product (GDP) over the next 75 years, based on estimates from the Treasury Department and the Urban Institute-Brookings Tax Policy Center.

  The cost of these tax cuts is *more than three times* the Social Security deficit over the same 75-year period, which amounts to 0.7 percent of GDP according to the just-released Social Security Trustees report for 2003. (The table at right also shows these comparisons in terms of present-value dollar amounts. Present value is the amount today that, with interest, would exactly cover future costs.)

	Present value over 75 years as % of GDP	Present-value cost over 75 years
2001 tax cut if made permanent	1.5% to 1.9%	$7.9 trillion to $10.0 trillion
Dividend proposal	0.3%	$1.6 trillion
Tax-free savings accounts	0.3%	$1.6 trillion
Other proposed tax cuts	0.2%	$1.1 trillion
Total Administration tax cuts	**2.3% to 2.7%**	**$12.1 trillion to $14.2 trillion**
Social Security actuarial deficit	0.73%	$3.8 trillion
Medicare Hospital Insurance actuarial deficit	1.11%	$6.2 trillion
Combined Social Security and Medicare HI deficit	**1.84%**	**$10.0 trillion**

- **The tax cuts are substantially larger than the combined deficits in Social Security and the Medicare Hospital Insurance program.** The projected deficit in the Medicare Hospital Insurance (HI) program — also known as Medicare Part A — is 1.1 percent of GDP, according to the trustees' report. The combined Social Security and Medicare HI deficit is 1.8 percent of GDP, well below the cost of the Administration's proposed tax cuts (2.3 to 2.7 percent of GDP).

  It also may be noted that even without the Administration's proposals to expand greatly the availability of tax-free savings accounts — the part of the Administration's proposals that has the smallest chance of being approved — the long-term cost of the tax cuts still is about three times the Social Security shortfall and greater than the combined Social Security and Medicare HI shortfall.

In calculating the long-term cost of the tax cuts, the Center's analysis assumes that their cost will remain constant as a share of GDP after 2013. This is the standard approach that the Congressional Budget Office, the Office of Management and Budget, and the General Accounting Office use when preparing long-term fiscal projections. In this case, such an approach is likely to *understate* long-term revenue losses because the costs of several provisions of the Administration's tax proposals, such as the creation of Retirement Savings Accounts and Lifetime Savings Accounts and the repeal of the estate tax, are virtually certain to grow faster than GDP for many years after 2013.

The Center's analysis concludes by noting that the nation faces significant long-term fiscal problems related to the baby boom generation's retirement, as well as needs that will require resources in other areas, including areas relating to children, the environment, the large number of Americans without health insurance, the lack of a Medicare prescription drug benefit, and the uncertain costs of homeland security. Other needs that cannot be foreseen today almost certainly will arise as well.

A balanced long-term fiscal policy is likely to entail some changes in Social Security and Medicare to reduce their future claims on the budget. The Administration's tax proposals, however, would make the long-term budget problem substantially worse and consume resources that could play a constructive role in Social Security and Medicare reform. Policymakers concerned about the long-term fiscal health of the nation would do well to consider the large long-term cost of the Administration's tax cuts.